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Original Articles.

CONGENITAL TROPHIC ŒDEMA.

By OTTO GRÜNBAUM, M.D., D.Sc.*

DURING the last few months three cases of congenital trophic œdema have come under my observation.

CASE 1.—T. R—, a male child, aged 3 months, was brought to the Belgrave Hospital for Children because the mother had noticed that the feet were swollen. The parents are healthy and have a child, aged 2 years, which is to all appearances normal. There is no history of abnormal labour, nor any suggestion that the cause of the deformity is due to maternal impression. I remember seeing a case some years ago which was ascribed by the mother to a fright from an elephant during the period of gestation! The feet alone are affected at the present time; the œdema is symmetrical. There are constrictions at each of the joints of the toes and at the ankles. The child is microcephalic, the circumference of the head being 27·5 centimetres.

* *Vide* p. 505. Read before The Society for the Study of Disease in Children, October the 21st, 1904.

Case 2.—The mother of the second child tells me that her mother had swollen legs "during all her life," but there seems to be some doubt whether the œdema was congenital. The father is a painter, but has never suffered from any signs of lead-poisoning nor from any illness whatever. The mother says that her feet swell towards evening, but are normal in the mornings. There are three children—a boy, aged 6 years, who is normal; a girl, aged 5 years; and a baby, aged 6 months; these two latter are affected with œdema of the feet and legs.

M. H— is an intelligent, well-nourished girl with well-marked œdema, and on her I have had an opportunity of making a few observations. The feet, legs, and lower half of the thighs are swollen, the two sides are symmetrical. That this œdema is considerable may be seen by comparing the measurements of her legs with those of a normal child of the same age and build:

	M. H.	Normal child.
Circumference of foot over instep	17·5 cm.	13·7 cm.
Around ankle	17·5 cm.	13·7 cm.
Around calf	20·6 cm.	20·0 cm.
Around knee	22·7 cm.	21·2 cm.

It is evident that the greatest œdema is of the foot and ankle. The toes are very swollen and constrictions mark the joints. The œdema is hard and only pits upon prolonged pressure. The legs are not tender, nor do they ache. Although the mother asserts that the size of the legs is just the same when the child is taken out of bed as when she is put to bed in the evening, nevertheless posture does make some slight difference in the limbs, but the difference in measurement is insignificant in comparison with the alteration in the consistency of the œdema. The legs are considerably harder after having been dependent for some time. The application of a rubber bandage to them diminishes the circumferential measurement by 5 to 7 mm.

The colour of the skin is normal: the temperature of the legs does not suggest any poverty of circulation.

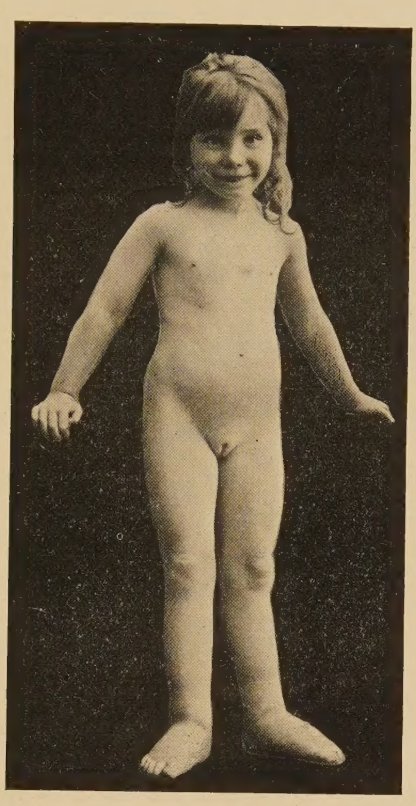
The blood-pressure in the brachial artery is 91 mm. of mercury. This is the maximum, measured by the obliterative method with C. J. Martin's modification of the Riva Rocci sphygmometer.

It is no easy matter to decide whether the skin of the legs is thickened, for the œdema of the subcutaneous tissue leads one to that conclusion upon the first examination; after prolonged massage

I was unable to satisfy myself that there was any permanent pathological alteration of the skin.

Sensation to light touch, pressure, heat, cold, and pain was normal.

A detailed examination of the blood did not seem to me to be devoid of interest, since I thought that it might possibly assist me to decide whether the œdema is due to dilated lymphatics or to excess



of lymph in the connective-tissue cells. Blood was taken from a finger and from an œdematous foot before and after massage. Care was taken to make a sufficiently deep incision with a small lancet to lead to a free flow of blood without manipulation. The blood from the finger was found to contain

Red cells . .	5,500,000 per cubic mm.
White cells . .	7600 „ „ „
Hæmoglobin . .	76 per cent.

(Haldane's modification of Gower's hæmoglobinometer). Blood from an œdematous foot contained :

Red cells . .	4,250,000 per cubic mm.
White cells . .	6600 „ „ „
Hæmoglobin . .	70 per cent.

After five minutes' vigorous massage of the foot blood withdrawn from it contained :

Red cells . .	3,240,000 per cubic mm.
White cells . .	6000 „ „ „

The last specimen of blood coagulated in 75 seconds at 22° C. (Wright's coagulometer)—*i.e.* considerably quicker than normal. Massage of normal tissues usually leads to a similar result to the one recorded above, but not to so great an extent. On pricking the skin of an area which has been quite recently massaged, tissue lymph pours out with the blood and dilutes it so that the number of cells per cubic millimetre is decreased. The fact that the dilution in this case seems to have been greater than normal suggests that the œdema is due to tissue lymph and not to dilated lymphatics, because these would have been partially emptied by massage. The comparison of differential counts of white cells in the blood taken from the finger and the foot corroborates this view :

	Finger.	Foot.
Polynuclear . .	49·0 per cent.	49·3 per cent.
Lymphocytes . .	40·3 „	40·7 „
Hyaline cells . .	4·0 „	3·4 „
Eosinophile . .	6·5 „	6·4 „
Basophile . .	0·2 „	0·2 „

(Over 500 cells were classified.)

The similarity of these counts makes it evident that the diluting fluid either contained white cells in the same proportion as the blood or was free from white cells. The fact that the number of white cells was less in the blood taken from the foot than in that taken from the hand makes it certain that the diluting fluid was free from white cells—in other words, that it was tissue lymph and not lymph from lymphatics. The percentage of polynuclear cells is very low for a well-nourished child of five years. The eosinophilia is suggestive of a parasitic affection. Filaria were not seen in any of the blood-films ; this, of course, does not prove their absence. It is quite within the limits of possibility that the increase of eosinophile cells is due to some intestinal parasite and has no relation to the œdema. The examination of the blood of the other cases illustrates this.

	T. R. (Case 1), aged 3 months.	J. H. (Case 3), aged 6 months.
Polynuclear . .	32·4 per cent.	29 per cent.
Lymphocytes . .	63·6 „	63 „
Hyaline . .	1·6 „	6 „
Eosinophile . .	2·4 „	2 „

I think that the above facts point towards the condition being due to œdema of the connective-tissue cells and not to dilated lymphatics.

Case 3.—J. H—, a male child, aged 6 months, was admitted into the Belgrave Hospital under Mr. Jaffrey, whom I have to thank for his kindness in allowing me to describe the case. He presents a very similar condition of feet and legs to his sister (Case 2). The feet and legs are swollen, but the feet to a much greater extent than the legs. The skin of the legs is thickened. The skin around the joints of the toes constricts them into three almost spherical masses; the œdema of the terminal phalanges is so great that the plane of the toes is tilted to almost a right angle to the long axis of the toes. The soles of the feet are affected as well as the dorsa; the heels appear to be normal. The measurement around the instep is 13·1 cm., about 1·3 cm. more than the same measurement of a child of the same age.

Since I have three cases only to add to the list it would be out of place for me to give a detailed summary of the numerous instances of this condition which have already been recorded. It may, however, be of interest to see how many varieties of this condition have been described and to note how they differ one from another. Hereditary angeio-neurotic œdema was described by Osler in 1888, but this is quite a different disease from the one under discussion, for the œdema is not persistent and affects different parts at different times. It is, as is well known, associated with other neurotic symptoms, not rarely with intense abdominal neuralgia.

Milroy,* in 1892, wrote a paper on "An Undescribed Variety of Hereditary Œdema," in which he referred to twenty-two individuals in a family of ninety-seven affected with this complaint. The above cases I believe to be similar to those described by Milroy. Meige† recorded trophic œdema in two sisters; in one of these the disease was unilateral. These cases were not congenital. Debove‡

* 'New York Medical Journal,' 1892.

† 'Nouvelle Iconographie de la Salpêtrière.'

‡ 'Presse Medicale,' 1902.

has termed a condition in which the œdema does not occur *en masse*, but which affects thighs or feet and not toes, as segmental œdema. In one of his cases the œdema began sharply at the gluteal fold and ceased at the popliteal space. There was not any thickening of the skin. Feindel * portrays two sisters affected with œdema in which the disease was asymmetrical and progressive. Osler † has described cases of sclerodermia accompanied by œdema, but in these the sclerodermia seemed to be the primary affection. Rolleston ‡ described a family in which persistent œdema was a marked feature; in his cases the œdema was distinctly diminished by raising the legs; the skin was not thickened.

The conditions which must be recognised are: (1) Congenital hereditary œdema—(*a*) symmetrical, (*b*) asymmetrical; (2) trophic œdema developing in later life; (3) persistent hereditary postural œdema; (4) segmental œdema; (5) sclerodermia with œdema.

TWO CASES OF CONGENITAL DIAPHRAGMATIC HERNIA.

By Sidney Gilford, M.B., Ch.B.,§
House Physician, Paddington Green Children's Hospital.

The two following cases recently admitted into the Paddington Green Children's Hospital are of interest, as they represent a rare variety of congenital diaphragmatic hernia.

Case 1.—A female child, aged 4 months, was admitted on December the 3rd, 1903, in a moribund condition, under the care of Dr. Guthrie. The child was unconscious, with sunken fontanelle and internal strabismus of the left eye. Her temperature was 103·8° F. The pulse was imperceptible at the wrist, and the respiration was slow and sighing. There was retraction of the abdomen, but no *tâche cérébrale*. Death took place fourteen hours after admission. She was sick six times, each time bringing up dark brown vomit. It was thought probable that she was suffering from cerebral thrombosis.

Post mortem.—Body well nourished. On opening the abdomen

* 'Gaz. Heb. de Med. et Chir.,' 1902.

† 'Journal of Cutaneous and Genito-Urinary Diseases,' 1898.

‡ 'Lancet,' 1902.

§ Read before the Society for the Study of Disease in Children, October the 21st, 1904.

the liver was found to extend almost down to the symphysis pubis, and the gall-bladder, which was in the middle line, was in contact

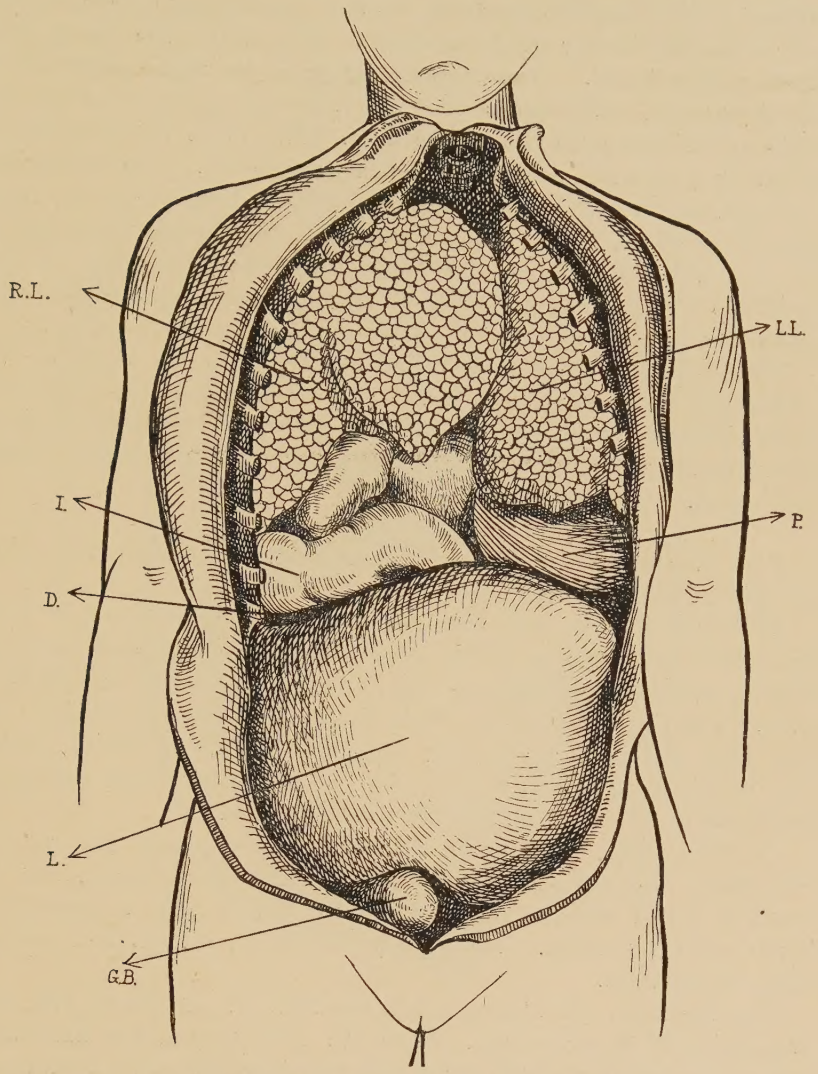


Fig. 1.—Case 1.—R.L. Right lung. L.L. Left lung. I. Intestine. P. Pericardium. D. Diaphragm. L. Liver. G.B. Gall-bladder.

with it. The liver was rotated so that the upper surface looked forward.

On opening the chest it was found that the whole of the lower and external portion of the right side was occupied by the large and

small intestines, the right lung being displaced upward and towards the middle line. The anterior mediastinum and the heart were displaced to the left, the right side of the heart being entirely to the left of the left border of the sternum. The diaphragm was pushed down and flattened. The stomach occupied its usual position, but the duodenum, which had a mesentery, passed upwards and to the right and disappeared behind the liver. The large intestine passed obliquely across the abdomen to reach the rectum. The abdominal contents, which had passed through the diaphragm into the right side of the chest, were the third part of the duodenum, the jejunum, the ileum, the ascending and transverse colon, and part of the pancreas. There was no sign of strangulation; and fæces were present in the lower part of the intestine and appeared normal.

The opening in the diaphragm was lying to the right of the middle line external to the crus. Its circumference was about two inches, and the peritoneum was continuous with the parietal layer of the pleura. All the organs appeared healthy, and no cause of death was found.

Case 2.—A male child, aged 4 months, was admitted on May the 24th, 1904, under the care of Dr. Sutherland.

History.—He was well until six weeks ago, when he had what his mother described as a fit, accompanied by cough and cyanosis. Similar attacks occurred frequently, and finally he was sent in by a doctor who thought there was fluid in the right pleural cavity. He had been fed upon breast-milk only, and had always taken it well. The bowels were usually regular, but he frequently had abdominal pain, and occasionally suffered from constipation.

On admission.—There was extreme cyanosis, and his rate of respiration was 82. A hot bath was given immediately, and he was put to bed with hot bottles around him, and with a turpentine stupe upon his chest. He rapidly recovered, smiled, and seemed quite comfortable.

May the 25th.—His temperature was 99·2° F., pulse rate 124, and respiration 30 to the minute. He had a good colour, but his cough was very troublesome, and respiration was accompanied by an indrawing of the whole subcostal region during respiration, and much wheezing during expiration. There was no movement of the alæ nasi. Slight dulness and diminished breath-sounds were present over the right lung posteriorly, suggesting collapse of the lung, and a turpentine stupe was accordingly put over that region. Rhonchi were present in large numbers over both lungs in front and behind.

The abdomen was very rigid and much distended. The edge of the liver was not felt.

May the 26th.—After a bout of crying he apparently fell asleep,

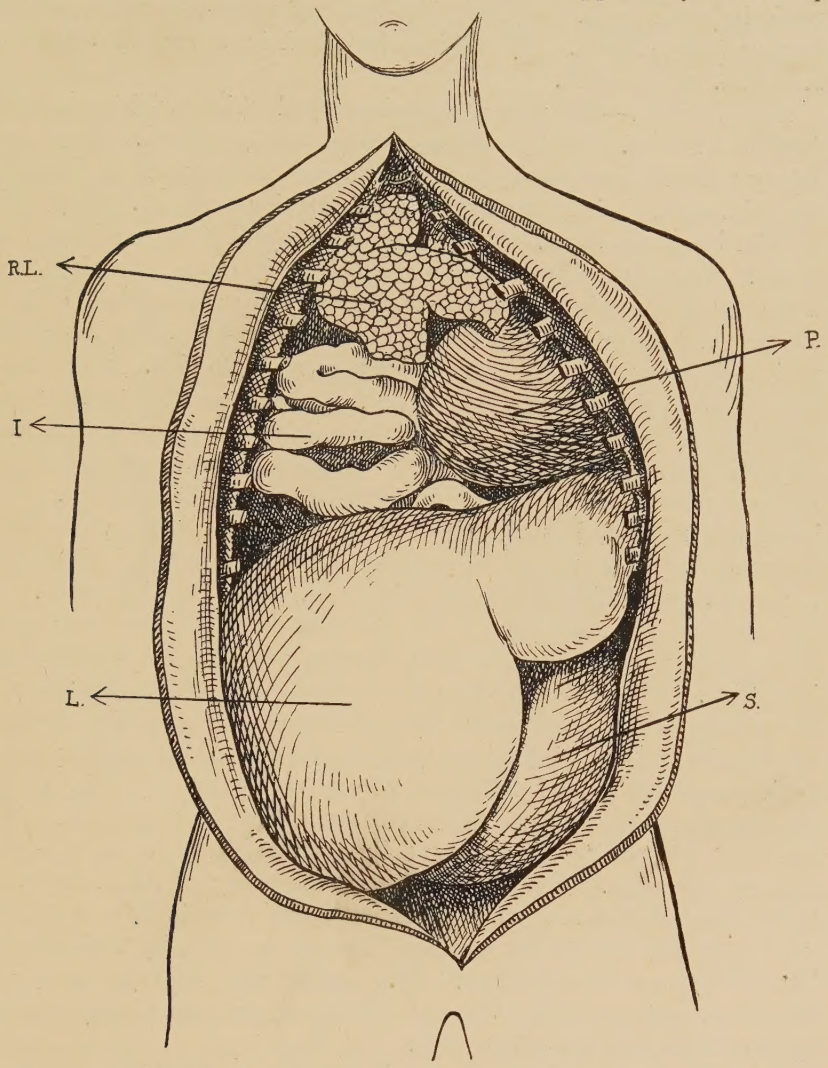


Fig. 2.—Case 2.—R.L. Right lung. I. Intestines. L. Liver. P. Pericardium. S. Stomach.

but was noticed to be sweating profusely, and had marked cyanosis and distress. Artificial respiration quickly improved the colour, and the child breathed easily. Two similar attacks occurred during the day, which were relieved when the child passed flatus.

May the 27th.—At 11.30 p.m., with no previous exertion, he was noticed to have become cyanosed, and to be suffering from great inspiratory difficulty and expiratory stridor. The lower interspaces were indrawn upon the left side, but not upon the right, and air hunger was extreme. He rallied, but died in a second attack at 1.45 a.m. on the 28th.

Post mortem.—He was a well-developed child, with firm, well-formed muscles. The fontanelle was nearly closed. The liver nearly reached the symphysis pubis, the presenting part, on opening the abdomen, being the upper and anterior surfaces. The gall-bladder was not seen. The stomach occupied the remaining part below. The lower part of the pleural cavity upon the right side was seen to contain nothing but intestine, the superficial coils of which were distended, and those behind collapsed. The heart and pericardium were pushed over entirely to the left side. The upper lobe of the right lung, pale and firm, was the only part of the two lungs to be seen. The left lung appeared to be healthy. The middle and lower lobes of the right lung were collapsed and slate-grey in colour and had probably never been expanded. The heart was normal, but the right pulmonary artery and veins were very small. The opening in the diaphragm was situated about two inches from the middle line and did not involve the right crus. It lay opposite the attachments of the diaphragm to the tenth and eleventh ribs, and admitted three fingers readily. It was circular in outline. There was no sac of any kind, but the parietal layer of the pleura and the peritoneum were in direct communication through the opening. The abdominal viscera present in the right pleural cavity consisted of the third part of the duodenum with the tail of the pancreas, the jejunum, ileum, cæcum, and ascending colon. The duodenal end was firmly adherent by its mesentery to the posterior part of the ring. The whole of the mesentery of the small and large intestine was abnormally long, and the hepatic flexure of the colon was attached to the anterior part of the ring by a firm band. There was no strangulation. The spleen and kidneys were not displaced, and the liver was not deformed, but was merely rotated upon a horizontal transverse axis.

It would seem that the diagnosis of such a condition should be comparatively easy. One would expect to find the marked displacement of the liver, and to have a tympanitic note and diminution of the breath-sound over the lower part of the right side of the thorax. Unfortunately neither child was in a condition suitable for thorough examination. The first was moribund on admission and evidently had

only a few hours to live, whilst the second child cried whenever he was examined and soon got acutely distressed. The loud rhonchi present prevented any exact auscultation. In neither case was the diagnosis of diaphragmatic hernia thought of. In Case 2 the abdomen was rigid and distended, and the edge of the liver could not therefore be felt readily. The physical signs in the thorax are interesting to note. The collapsed lung at the back gave an area of diminished resonance with diminished breath-sounds, and the child's respiratory distress was thought to be largely due to this collapse. The note in front was not markedly tympanitic, as might have been expected. This is probably due to the fact that as the child was examined in the intervals of comparative comfort, there must have been very little flatus present in the intestines. This is shown by the fact that the child's distress was so frequently noted to have been relieved by the passage of flatus. The adventitious sounds heard all over the chest obscured the true breath-sounds. The child had been sent in by the doctor, according to the mother's statement, for an operation for fluid in the right side of the chest.

A case of diaphragmatic hernia upon the left side with the stomach and part of the intestines in the thoracic cavity was recently operated upon in one of the children's hospitals for a supposed left empyema, although repeated exploration had failed to confirm the diagnosis.

Hillier showed a specimen, before the Pathological Society in 1861, of a diaphragmatic hernia upon the right side with the colon within the thoracic cavity. The child had had attacks of dyspnœa since she was two weeks old and died at seven months with no intestinal symptoms. In this case the note was dull at the lower part of the thorax on the right side and tympanitic above. The absence of any intestinal symptoms in all these cases is rather striking.

An indication of the cause of such hernia may be obtained from a consideration of the development of the diaphragm. Five elements—one median, two ventro-lateral, and two dorso-lateral—enter into the formation of the diaphragm. The median and ventro-lateral are first developed and together form the septum transversum. At a later period the two dorso-lateral elements, which are only present in mammals, are formed and unite with the septum transversum to form the "primitive pleuro-peritoneal septum," and completely shut off the pleural from the peritoneal cavity. It is easy, therefore, to understand why congenital diaphragmatic herniæ should almost invariably occur at the posterior part of the diaphragm. After the second or third month of intra-

uterine life the diaphragm is completed by the growth of muscular fibre springing, firstly, from around the œsophagus and, secondly, from the chest wall at the periphery of the diaphragm.

Both of these herniæ must be included among those classed by M. Nau as "embryonic diaphragmatic herniæ"—*i.e.* herniæ formed before the complete closure of the "pleuro-peritoneal septum," and those which have not therefore acquired a sac. He divides this class into complete, where the whole of the dorso-lateral element, or pillar of Uskow is deficient; incomplete where it is partially absent, and complex where the opposite one is also deficient. These cases will, therefore, come under the division of "incomplete embryonic diaphragmatic hernia."

M. Paillard in his Paris thesis of November, 1903, has put together statistics obtained by Bowditch, Lacher, Kohn, and Boursier, and has classified 130 cases which he has himself collected. In a total of 481 he has found that 93, or practically 20 per cent., have occurred upon the right side. Amongst his own 130 cases he describes 74 complete embryonic diaphragmatic herniæ, of which 15 occurred upon the right side, and in 14 of these the liver, much deformed, was partially within the pleural cavity. He has found only 16 cases of incomplete embryonic diaphragmatic hernia, and of these only 2 occurred upon the right side. One of these contained the small intestine, and the other the small intestine, cæcum, and right kidney. Thus in his 130 cases there were none similar to these two which presented such a remarkable resemblance to each other. It is a strange thing that rare conditions so frequently occur in pairs in a hospital practice.

I have to thank Dr. Guthrie and Dr. Sutherland for permission to publish these cases, and Dr. Emery for the notes of the post mortem in Case 1.

The drawing of Case 1 was taken from a photograph, that of Case 2 from a sketch made at the post mortem.

APPENDICITIS IN A CHILD DISCOVERED BY RECTAL EXAMINATION.

By Dan McKenzie, M.D.

The subject of rectal examination in children received recognition in 'The British Journal of Children's Diseases' for October,

1904, at the hands of Mr. P. Lockhart Mummery, who, in the course of his observations, drew attention to Dr. George Carpenter's original contribution in 'Pediatrics,' in June, 1896, on the great importance of rectal bimanual examination for the diagnosis of a variety of abdominal disorders in early childhood, together with an account of that writer's methods. Dr. George Carpenter records in the above-mentioned communication a diverse number of conditions in which this method of examination was of the utmost assistance to him in arriving at a conclusion. Thus, constipation occasioned by a sacral tumour; an umbilical fistula secondary to a prostatic abscess; a horse-shoe kidney simulating tuberculous peritonitis; tuberculous peritonitis and its distinction from chronic gastro-intestinal catarrh with abdominal enlargement; abdominal abscesses secondary to appendicitis and other causes; tuberculosis of the ureters, impaction of calculi in the ureters, vesical calculus, hydro-nephrosis and pyo-nephrosis; tuberculosis of the uterus and adnexa; ovarian tumours; hydatids and congenital mesenteric cysts, are some of the subjects that are there dealt with by him. This paper also contains details of guidance for the conduct of examination of the female pelvic genitalia, and in Vol. III of the 'Reports of the Society for the Study of Disease in Children,' pp. 79 to 91, under the heading of "Tuberculous Peritonitis," are further observations by Carpenter on tuberculous disease of the female internal genitalia and other pelvic disorders in infants and young children, an account of the conditions of which, during life, by bimanual examinations, he was the first to introduce, and of which a valuable illustration was given by him in the October number of the JOURNAL under the heading of "Gonorrhœal Inflammation of the Uterine Appendages in a Girl of 3½ years, detected by Bimanual Examination; Spontaneous Recovery."

He has also insisted upon the importance of this method of examination in 'Golden Rules for Diseases of Children,' under the headings "Intestinal Obstruction" and "Tuberculous Peritonitis"; and the plan is so valuable that it should be widely known and practised.

The following account is therefore of interest as emphasizing what has already been said, viz., that rectal examination should be undertaken as a matter of routine in all doubtful cases of illness in children, more especially in those in which the symptoms point to the abdomen as the seat of the disturbance.

T. G—, aged 4 years, was first seen on December the 1st, 1903, suffering from pyrexia and general malaise. Temperature 101° F. As

he was subject to periodic attacks of acute gastric disorder resulting from injudicious dietetic indulgence, nothing out of the way was expected in this attack, and, although he was examined in the ordinary manner, nothing was found. Next day, with a temperature of 103° F., he was complaining of stomach-ache together with pain on micturition. Examination of the abdomen was unsatisfactory from the refractory nature of the child, but as far as could be made out the abdomen was hard and seemed to be tender. *Per rectum* the bladder was felt to be full and fluctuating. With the expectation of discovering some cystic trouble the patient was anæsthetised and a catheter was passed into the bladder with ease and without happening upon anything to account for the symptoms. Rectal examination, however, at once revealed the cause of his illness, for, on palpating the pelvis and abdomen bimanually, an oval rounded tumour about the size of a pigeon's egg was found, lying towards the right side of the pelvis, in the right iliac region. Appendicitis was diagnosed, and the same evening the diagnosis was confirmed and the appendix removed by Mr. Marmaduke Sheild, chloroform being administered by Mr. Ernest Cross. In the appendix were several perforations and the organ was found lying in a bath of pus, so that if the diagnosis had been delayed, even for a day or two, the boy would in all probability have lost his life.

The convalescence was complicated, curiously enough, in view of the previous dysuria, by the passage of a fairly large uric-acid calculus, an event which sent up the temperature for a day or two and was heralded by hæmaturia, but thereafter the boy did perfectly well.

The pelvis in a child is, of course, so much shallower than in an adult that we are able with the finger in the rectum to investigate the condition of the abdomen much more completely than can be done in later life. My experience of this mode of examination has been that, in order to obtain a satisfactory result the patient, as in the foregoing case, must be anæsthetised.

Leytonstone.

Clinical Memoranda.

A CASE OF HERPES ZOSTER EXTENDING TO THE FINGER-TIPS.*

By George Carpenter, M.D.

Herpes zoster extending to the fingers is rare in any event, especially so in children. The accompanying photographs well

Fig. 1.

Fig. 2.

illustrate the condition which I observed some years ago in a child under my care at the Evelina Hospital for Children. The eruption affected an extensive cutaneous area, viz. the front and back of the upper part of the chest, the arm and forearm in front and behind,

* Exhibited before The Society for the Study of Disease in Children, October the 21st, 1904.

the back of the arm, also the palm of the hand and the little, ring, and middle fingers, with a small patch at the root of the little finger on the back of the hand. The nerve roots affected were the eighth cervical and the upper three dorsal nerves. The girl made an uninterrupted recovery and nothing worthy of note occurred in the case.

The Society for the Study of Disease in Children.

An Ordinary Meeting was held at the Medical Society's Rooms, 11, Chandos Street, Cavendish Square, W., on Friday, November 18th, 1904, Mr. Robert Jones (Liverpool) in the chair.

A Specimen of Congenital Atresia of the Tricuspid Valve was shown by Dr. Bertram Rogers (Bristol) and Dr. J. M. Fortescue-Brickdale (Bristol). The child, aged 2 years, was admitted into the Children's Hospital, Bristol, suffering from bronchitis with extreme dyspnœa and cyanosis. The fingers and toes were clubbed, and the lips and extremities deep purple. There were no cardiac bruits and no apparent increase of cardiac dulness. She had suffered from repeated attacks of cyanosis. She died in a few hours. Post mortem the heart weighed $3\frac{1}{2}$ ounces. When opened it showed hypertrophy and dilation, mostly of the right auricle and left ventricle, patent foramen ovale, atresia of the tricuspid orifice, and a small opening between the ventricles. There was no sign of endocarditis; the ductus arteriosus was closed. Dr. Fortescue-Brickdale compared the condition with that of a child described by Sievking in 1853 at the Pathological Society, whose heart is now in the museum at St. Mary's Hospital. He attributed the cyanosis to the very deficient aeration of the blood, and to the venous engorgement produced by the obstruction at the foramen ovale. The hypertrophy and dilation, which were partly mechanical, he thought in a measure due to the exaggerated action of the heart in response to the call for oxygenated blood.

A Specimen of Congenital Pulmonary Stenosis was shown by Dr. George Carpenter. The condition was associated with a perforate septum ventriculorum and a patent foramen ovale. The aorta in great part arose from the right ventricle. The heart was removed from a girl of two years. There was no history of syphilis or rheumatism, and the child was free from other congenital abnormalities. The right ventricle was hypertrophied and during life this was an obvious feature. There was a loud systolic murmur audible all over the precordial area and of maximum intensity at the xiphoid cartilage; it was inaudible in the great vessels of the neck and only occasionally heard in the back. The lips were cyanosed, and the fingers and toes blue and clubbed. The child was born blue, and the cyanosis had latterly increased—she had twice been convulsed. The red corpuscles were 7,800,000 per c.mm., and the hæmoglobin 122 per cent. She died of measles. Dr. Carpenter drew attention to the large increase in the number of red corpuscles and of the hæmoglobin percentage, which in his experience

was not an uncommon feature in cases of congenital morbus cordis with cyanosis. He also commented on the value of the skiagram in such cases, also on the advent of cyanosis in the subjects of congenital morbus cordis, which was quite often a delayed phenomenon. The absence of a systolic bruit in the great vessels of the neck was touched upon, and its value when audible there as a diagnostic sign of the condition of perforate septum ventriculorum was, he thought, of considerable importance.

A Specimen of Atresia of the Pulmonary Artery was shown by Dr. Sydney Curl. It was removed from an infant who was the subject of hare-lip and cleft palate. The septum ventriculorum was patent and the auricular septum was incomplete, the auricle forming one chamber. The aorta was large and sprang from both ventricles, but chiefly from the right. During life the child was not cyanosed, and congenital malformation of the heart was not suspected. There was no bruit, but the infant had attacks of dyspnœa with cyanosis.

Dr. E. Cautley asked each exhibitor whether there had been a history or evidence of syphilis in any of the cases. He believed syphilis to be the great cause of congenital heart disease. He confirmed Dr. Carpenter's observations as to the excessive number of red cells and of hæmoglobin in cases of congenital heart disease; it was often found, but it was not obvious why.

Dr. Fortescue-Brickdale (Bristol), in reply, said that in his case there was no evidence of syphilis as far as he could make out.

Dr. George Carpenter, in reply, said he was in favour of the view expressed by Dr. Cautley as to congenital syphilis being responsible for a certain number of cases of malformation of the heart. He had encountered cases in which that evidence was undoubted, but errors of development and rheumatism and other blood infections were very frequent causes.

Dr. Sydney Curl, in reply, said there was no evidence of syphilis in his case.

A Case of Juvenile General Paralysis was shown by Dr. James Taylor. The patient was a boy aged 11½ years, the fifth in a family of nine, all said to be healthy. He was born at full-term, suffered from abscesses "in the head and groin" at 1, but did not walk till he was 4. At 6 he developed a faculty for romancing, telling wonderful stories apparently merely to excite admiration. He was also frequently violent and vicious. He attended school and had reached the third standard, when about three months ago his sight failed. He came to Moorfields, where he was seen by Mr. Treacher Collins, who referred him to the exhibitor. He is a small, badly-developed boy without any stigmata of syphilis. He has very much impaired vision, the pupils do not respond to light, and there is well-marked optic atrophy. He walks rather feebly and a little unsteadily, his knee-jerks are active, and his plantar reflexes extensor in type. His mental condition is one of more or less placid contentment with everything. Before he was admitted into hospital he cherished delusions that he was a wonderful singer, and would gather children round him in order that they might hear him sing. The physical signs and the mental symptoms, slight as they may be, appear to indicate definitely that the case is one of juvenile general paralysis, and the physical and mental degeneration is likely to become much intensified.

Dr. Parkes Weber narrated the case of a youth, aged 19 years, with

general paralysis of the insane. Tremors began eighteen months previous and he gradually lost ground physically and mentally. The tremors affected all the limbs and were somewhat diminished by voluntary movements. He saw the patient two years later, and he was then helpless, apathetic, wet, and dirty. The lower extremities were rigid, and there was decided ankle clonus. He asked whether the tremors in such cases in children had any special significance.

Dr. James Taylor, in reply, said with regard to tremor, he did not think that it was by any means a constant early symptom of general paralysis, and tremor was not constant in children the subjects of the disease.

Dr. Parkes Weber said his chief point was as to whether the tremor did not indicate the presence of some inflammatory lesion in the cerebral cortex, possibly syphilitic.

Dr. Taylor, continuing, said he thought it was scarcely necessary to assume the presence of some special process to account for a particular degree of tremor; its extent seemed only to depend on the intensity of the general paralysis.

Two Cases of Cephalhæmatoma Neonatorum over the Occipital Bone were shown by Mr. J. Howell Evans, who subsequently gave a lantern demonstration on the subject. Mr. Evans considered these blood effusions were due to a reactionary hæmorrhage from a small artery which had been injured in the moulding of the infant's head during its passage through the birth-canal. Fœtal skulls and many lantern slides of the skulls of various animals were shown to illustrate Mr. Evans's original views. The author advocated the immediate surgical treatment of cephalhæmatoma neonatorum and drew attention to his former observations on this subject.*

The Chairman (Mr. Robert Jones, Liverpool) said he remembered once in the out-patient department of the hospital seeing a case where, in a hurry, a cephalhæmatoma was opened and everything became septic. If the operation were done at all, it should be performed with the utmost caution.

Dr. C. W. Chapman said that, years ago, when he was seeing such cases, the condition got absolutely well after being left alone. He would not recommend anything to be done in the way of operation.

Mr. Howell Evans, in reply, said leaving these tumours alone was the advice which had generally been given and adhered to, but he could not find throughout the whole of the writings on the subject any person who had viewed the condition in the light of reactionary hæmorrhage. If it was right to treat surgically a reactionary hæmorrhage in the leg, why not operate for a similar condition on the delicate skull of a child? By prosecuting his studies further, he believed that in time he would be able to prove that nearly all the spastic congenital hemiplegias of which neurologists wrote were due to neo-natal traumatisms associated with those very vessels which were passing from without the skull into its interior.

Three Cases of Unilateral Congenital Dislocation of the Hip of varying degrees of severity were shown by Mr. Douglas Drew. He brought the cases forward with the idea of obtaining expressions of opinion as to the treatment. Mr. Drew thought in one case that no treatment, either operative or manipulative, was needed, as the child walked extremely well with

* "The Relation of Certain Extra- and Intra-cranial Hæmorrhages in the New-born," 'British Journal of Children's Diseases,' May, 1904.

the aid of a slightly raised boot. In the other case, in which the deformity was more pronounced and walking more difficult, Mr. Drew thought that operative measures would be needed, and expressed the opinion that he should choose the open operation in preference to the manipulative.

Mr. Lewis McGavin said he had seen five cases which were operated upon four or five years ago. They were submitted to the open operation, and three of them died as a result—one from shock, two from septic sequelæ. Of the two which recovered, one relapsed completely to its original condition —and, indeed, was rather worse—and the last had ankylosis of the hip. However unsatisfactory Lorenz's operation had been in its results, one should not submit young children to the open operation without most careful consideration.

The Chairman (Mr. Robert Jones, Liverpool) said the subject was such a huge one that a general discussion of it could not be entered upon then and there. He had seen bad results from both forms of operation. There were many cases of ankylosis resulting from the open operation, by the best men, and he had seen fractures of the neck of the femur in attempting reductions. The point upon which all would agree was, that if the little child brought forward by Mr. Drew walked as well fifteen or twenty years hence as now, no one would ever think of adopting a manipulative process or the open operation. But unfortunately, that was not quite the history of such cases. It had constantly occurred to him that people brought children of 15 or 16, and even persons of 20 to 30 years of age, in whom the trouble had been congenital dislocation. The abduction became more limited, there was considerable pain, and degenerative changes took place sooner in the heads of the bones at that period, and the after-effects, as a rule, were not good, even in the cases left alone. Surgeons had not lived long enough to know precisely what the after-results would be in cases manipulated and treated by the Lorenz method, and certainly not by the open method. It should be remembered that Professor Hoffer, who was the pioneer and did the greatest work on the open method, had now practically discarded it; he did it now only in exceptional cases and in older children. And Lorenz himself had stopped operating in that way. Why? Surely not because the results were good. And when one heard of gentlemen who had six or eight cases, four or five of which were good, one must abstain from drawing definite conclusions from that small series; conclusions should be based upon a whole mass of cases. He himself was not at all averse to Lorenz's operation; he had performed it many times, and at the Bristol meeting he showed 35 radiographs in different stages. He had had a fair percentage of bad results, stiff joints resulting, and abducted feet, but they were due to his having chosen the wrong class of case for the operation, or to his not having been sufficiently energetic in the matter of early massage. He had recently examined the two cases upon which Lorenz operated when in Liverpool, and they were both absolutely all right, the movement being perfectly free, and they were both unilateral cases. Skiagraphs also showed that everything was in place. He deprecated taking sides on the question; there was too often a partisan feeling thrown into the controversy. He had thought he would operate in the following way: Reduce the hip first, and if one found a thoroughly unsuitable acetabulum, to keep it in the reduced position a fortnight or three weeks, then take the dressings off and make the open incision, afterwards putting the parts through no manipulation. The anterior method seemed most preferable.

It was absolutely unscientific to do what Lorenz and others had done, namely, to try to chisel the head of the femur to fit the acetabulum. The whole result of that could only be ankylosis.

A Case of Old-standing Dislocation forwards of the Head of the Radius of two years' duration was shown by Mr. Douglas Drew. The dislocation was forwards and was reduced by operation, but in spite of the greatest care the condition recurred as soon as movement was permitted. Inasmuch as the function of the arm was very little impaired and the deformity was trifling, Mr. Drew advocated no further interference.

The Chairman (Mr. Robert Jones, Liverpool), said he had seen a great number of cases of dislocation forwards of the radius, and he could confirm what Mr. Drew said as to the difficulty of keeping them in position. He agreed with Mr. Drew that in cases of recurrence it was barely worth while running the risk that operation entailed.

A Case of Bell's Paralysis with a Hemiplegic Onset was shown by Dr. Porter Parkinson. The boy, aged 4 years, had been perfectly healthy till July last, when paralysis in the right arm and leg and face occurred suddenly. The weakness of the arm and leg passed away in a week, and, when examined, there remained only weakness of all the left side of the face. Dr. Parkinson thought the case due to a lesion of the nucleus of the facial nerve involving the pyramidal tract in some temporary manner, possibly passing œdema, and, from the sudden onset during the summer, with hyperæsthesia, in a previously healthy child, it resembled the lesion known as encephalitis inferior, pathologically similar to acute anterior poliomyelitis.

A case of ataxy of the cerebellar type was shown by Dr. J. Porter Parkinson, a girl, aged 4 years, who for four years had suffered from increasing inco-ordination in the movements of the arms and legs, with increased reflexes. She had also weakness of the ocular muscles, and diffuse choroido-retinitis scattered over the fundi of both eyes. There was mental impairment and an excessive emotional condition. The exhibitor suggested that she had a diffuse degeneration of the brain, with symptoms pointing to a special involvement of the region of the corpora quadrigemina, producing the ataxy, increased reflexes, and ophthalmoplegia. The condition of the fundi of the eyes suggested it was a degeneration occurring in hereditary syphilis, though there was no other evidence, personal or family, to corroborate this.

Dr. C. O. Hawthorne agreed with Dr. Parkinson's suggestions as to the condition of the fundus oculi being due to hereditary syphilis. The Bell's paralysis case he thought might also be explained as had been suggested.

Dr. E. Cautley said he thought Dr. Porter Parkinson's diagnosis in the case of Bell's paralysis depended mainly on the history. Personally, he mistrusted histories. He thought the child had got a mild attack of hemiplegia on the right side, and that during the course of it it developed a typical Bell's paralysis.

Dr. Porter Parkinson, in reply, agreed with Dr. Cautley as to the danger of accepting histories. With regard to the condition in the Bell's paralysis case being due to a lesion in the nucleus, he believed in that view because the facial paralysis came on at the same time as the arm and leg paralysis.

A Case of Graves' Disease in a boy, aged 12 years, was shown by Mr. SYDNEY STEPHENSON. The thyroid was enlarged, there was slight tachycardia, slight exophthalmos, and a curious pallid puffiness of each upper lid. There were no nervous symptoms.*

Dr. G. A. SUTHERLAND said he supposed comparatively few saw cases at the age of the present child, or even a few years later. The only case which he remembered seeing was that of a girl, aged 13 years, who suffered from seven attacks of chorea, and from symptoms of Graves' disease afterwards. He had had her under observation seven years, and the symptoms had gradually subsided. There was remaining some exophthalmos and enlargement of the thyroid, but apart from that she was quite healthy, and indeed was a very stout, robust girl.

Two Cases of Traumatic Keratitis following difficult Instrumental Labour were shown by Mr. SYDNEY STEPHENSON.*

Dr. C. W. CHAPMAN asked whether any albumin was found in the urine, because there was a moderate accentuation of the second sound, and duplication of the second pulmonic sound. The heart did not appear to be enlarged.

Mr. STEPHENSON, in reply, regretted that the urine had not been examined.

A Case of Progressive Palsy in a boy aged 13 years was shown by Dr. HARRY CAMPBELL (introduced). The paralysis began in the legs at the age of five years, and was noticed in the hands at the age of nine, and in the face at the age of ten. It was symmetrical, and in the extremities mainly confined to the long extensors. Electrical reactions were normal. Dr. Campbell was uncertain as to the nature of the affection.*

A Specimen of Tuberculous Ulcers of the Intestine was shown by Dr. SYDNEY CURL.

A Specimen of a Tuberculous Fallopian Tube removed from a case of general tuberculosis aged 2½ years, was also shown by Dr. CURL. It was not suspected during life. The uterus and ovaries were healthy.

The Glas-Sedlbauer Lamp for the light cure of lupus was demonstrated, an illustration of which appeared in the November number of the JOURNAL.†

Editorial.

EPIDURAL INJECTIONS IN THE TREATMENT OF INCONTINENCE OF URINE.

BY epidural injections we understand the method of injecting local anæsthetics into the space which lies between the periosteum of the

* An account of this case will appear in full in an early number of the JOURNAL.

† The lamp can now be seen in operation at the premises of Messrs. Krohne and Sesemann, surgical instrument makers, Duke Street, Wigmore Street, W.

vertebral column and the membranes of the spinal cord. This space is a complete cylinder traversed by the nerve-roots as they leave the vertebral column. The value of such injections in the treatment of enuresis was accidentally discovered in the following manner by Cathelin, a French physician. An American observer, Corning, had in 1885 been the first to attempt the introduction of foreign substances into the spinal column. He selected a spot situated between the third and fourth lumbar vertebræ, penetrating by his injections the membranes of the cord. This method of subdural or subarachnoid injection was further developed by Quincke, who perfected the technique of the operation and some years later introduced it into general use under the name of "lumbar puncture." Hallion then showed that a local anæsthetic, such as cocaine, when injected subdurally acts, not upon the spinal cord, but upon the nerve-roots of the cauda equina. There was thus no advantage in injecting the substance under the arachnoid, whilst there was always present the risk of the production of sepsis or injury to the cord. Acting upon this, Cathelin attempted to find a method by which he could reach the cauda equina without touching the cord. He performed a number of experiments upon dogs, and came to the conclusion that the lower opening of the sacral canal constituted the most convenient site of entrance into the canal. He injected coloured fluids at this point, and after death found traces of the pigment covering the surface of the sheath of the cord as high up as the cervical region, whilst none had entered the dural sac. This showed that he had reached the epidural space without penetrating the membranes or running the risk of wounding the cord. He thereupon attempted to produce analgesia by injecting solutions of cocaine into the sacral canal of human subjects. To his surprise the result was not analgesia, but retention of urine. In collaboration with Albarran, he then applied his method of injection to the treatment of conditions of abnormal frequency of micturition, and published a monograph upon the whole subject in 1901. The method was soon employed by other French and a few German observers. The results invariably appear to be eminently encouraging. A certain number of cases have been permanently cured, some as the result of a single injection, and considerable improvement is

reported in many others. Cathelin at first used cocaine, but later substituted normal saline solutions. Strauss uses Schleich's No. 2 solution with the morphia omitted, because he has found that this solution causes less local tenderness. Like Kapsammer and Cathelin himself, he has come to the conclusion that no marked difference exists in the action of the various solutions used. The injections may be made with an ordinary syringe bearing a needle of a length of 1½ in. in the case of children, or 2⅔ in. for adults. A quantity of from 1½ to 5½ drachms of sterilised normal saline solution may be injected at each sitting; or in obstinate cases as much as 10 or 11 drachms may be necessary. It is advisable to make two or three injections at short intervals even when the cure appears complete after the first; in this way relapses are avoided. In making the injections the patient may be in a standing position, but is best laid on his side with the thighs flexed so that the sacrum is thrown out. The membrane closing the lower end of the sacral canal has now to be looked for. The landmarks of the operation are constituted by the sacral cornua, *i.e.* the posterior and inferior processes of the last sacral vertebra. These are readily found in a child or thin subject, and without great difficulty in a fat person. Between these, at the posterior termination of the intergluteal fossa, a small triangular depression is seen. The needle is inserted at this point and thrust forwards and upwards into the sacral canal. The operation is technically easy and free from all pain save a slight degree of local tenderness. An anæsthetic is not required, and the injection may safely be performed upon out-patients, who are able in a few hours to follow their usual occupations. Provided that the ordinary precautions of surgical cleanliness are adopted the operation is free from all danger; of the thousands of cases in which it has been performed no noteworthy instances of untoward results have been recorded.

We possess no real knowledge as to the *rationale* of this method, but it has been suggested by Cathelin and others that the injections owe their effect to an irritation of the nerve-roots of the cauda equina. The irritation spreads to the medullary centres of the spinal cord and sets up in these a reflex excitation of the molecular elements which produces inhibitory changes in their functional activities. In

consequence of this the tonus of the previously insufficiently enervated sphincter is stimulated and the latter enabled to functionate more actively.

Whatever may be the true explanation, the sound practical results which have been obtained seem to show that we possess in this method a genuine addition to the varieties of treatment at present adopted in cases of enuresis. The method has up to the present attracted little or no attention in this country, and it appears to be worthy of an extended trial. Its chief use lies in the treatment of the enuresis of children, but it has also been successfully employed in the incontinence of urine without mechanical cause in adults, in spermatorrhœa, neurotic polyuria, and other similar lesions of the genito-urinary system.

The method is now being tried at the North-Eastern Hospital for Children by Drs. George Carpenter and E. P. Baumann, who will publish their results.

A Retrospect and a Forecast.

Twelve months ago the first number of the 'British Journal of Children's Diseases'—as also the first of a wholly British venture in this special branch of study—was in course of preparation, and with this issue its first year is now successfully brought to a close.

In the Introduction to our first number we duly recorded the unsuccessful attempt we made some years back to interest medical men in this country in the study of children's disorders by the simultaneous publication of an English and American edition of 'Pediatrics'; one twin survived, and is now well grown and sturdy, but the other "pined away" from inanition.

Twelve months ago the creation of this publication was not entered upon without some misgivings in view of the unfortunate fate of its predecessor. Although it was natural there should arise on that account some want of confidence in the launching of a similar venture, yet this perhaps not uncalled for hesitation was backed by a strong determination to profit by past experiences and to compel success on the present occasion.

The programme that we then set ourselves to accomplish has been

carried out; and who on perusing the pages of this journal, which will soon appear in volume form, can deny that we have satisfactorily redeemed our pledges?

Many of the original communications that have appeared from time to time in our pages have been of exceptional worth, and go far to prove that this country is lacking neither in men nor in desire for the advancement of knowledge of pediatrics, nor in material for the prosecution of those studies which tend to promote the welfare of the young and the morale and physique of the nation.

That a large and unexplored field of research on children's ailments is open to the diligent student of medicine is evidenced by the wealth of work which is produced by foreign countries in this particular branch of study, as will be clear to all who will take the trouble to peruse our abstracts from the world's current medical literature. Individually, in respect to children's specialists, it will, no doubt, be admitted that Great Britain is not behind other countries, but collectively in relation to a knowledge of children's disorders its medical men are not in the van.

It is freely alleged by many practitioners that there is no necessity for the special study of children's complaints, but that this is obviously an incorrect idea is evidenced by the good work which is daily being produced by foreign specialists.

In the course of time the advent to power of those possessing more modern views on this subject and in the natural order of things the retirement of those who are opposed to reform and whose ideas are mediæval will be productive of a very welcome change, much to the children's advantage.

The medical student, in the process of his education, will not then pass by the ailing infant as of no importance in his daily progress through the wards and out-patient departments of his *alma mater*. Before the millennium we hope his mental appetite will be sharpened by the prospect of a stiff practical examination in pediatrics prior to being legally qualified to practise his honourable calling on the children of the public. But before this can come about the subject should be taught in the medical schools by men who have made a special study of this branch of medicine.

In those halcyon days it is to be hoped that diseases of women and children will not be taken together, as is still the custom in very many institutions. When the authorities who are responsible for medical education have ordained that the student shall undergo a course of instruction in children's complaints and shall be *specially examined*

as to their knowledge in respect to these matters, the alarming infantile mortality which we all must deplore will happily sensibly diminish.

It is ridiculous to condemn mothers for the loss of their offspring and to bewail the high infantile mortality rate—for this excessive mortality is not confined to the poorer classes—when their professional mentors have received no special training in infantile dietetics and management and are therefore incapable of imparting knowledge to their patients which they themselves do not possess.

That the future race of medical practitioners should start on their medical career equipped with at least an elementary knowledge of infant feeding and of childish ailments is the minimum that the public have a right to expect from them.

Outside this aspect of the case there is a growing demand for the special study of pediatrics by the medical practitioners of this country; the ever-increasing membership of the Society for the Study of Disease in Children and its well-attended meetings testify to it. Let those who think otherwise, and who imagine that by shutting their eyes to facts, or by holding aloof, or by sitting on the fence, they can stem the tide of a popular movement, see for themselves and note the trend of advanced medical opinion. A recently-founded Medical Society that can show the enrolment of twenty new members at its inaugural sessional meeting, whilst an old-established and well-known Society can claim but four, indicates its growing popularity. The fourth annual volume of its 'Reports,' which has recently been published, is one of which its members can be justly proud, and is prophetic of the great future which awaits this Society.

Further, as indicating the growing interest of the medical profession in this special branch of practice, the 'British Journal of Children's Diseases' has proved a phenomenal success; it has rapidly leaped into popularity; its subscribers hail from all parts of the Empire, at home and abroad; it has established exchanges with all the leading medical publications throughout the world, in whose pages abstracts from its columns will be frequently found; it has evidently filled a distinct want; it now occupies an assured position, and all this has been accomplished in the short space of twelve months.

Let it not be imagined, however, that we who are responsible for its foundation are therefore perfectly satisfied with it in its present form; we are alive to its shortcomings as well as to its numerous good features, and our policy will be progressive; endeavours will be made from time to time to improve it when im-

provement is necessary, so that its pages may prove of service to the family practitioner as well as to the specialist. With this object in view it is our intention, commencing with the January issue of the second volume, to provide monthly a clinical lecture, special to the JOURNAL, by various and well-known writers at home and abroad on practical subjects which will prove of service to family practitioners on their daily rounds. On the other hand, the scientific side of the JOURNAL will be kept well up to date, and the abstracts from current medical literature will be more numerous and more varied than heretofore—an epitome of hospital practice and gleanings from the laboratories of foreign workers. There is an obvious advantage to be obtained by the inclusion of records of interesting cases and research work in special departments under one cover, as it prevents their loss to science and greatly facilitates reference and therefore saves much valuable time to the busy family practitioner and the scientific worker. To both classes the JOURNAL will be found of great advantage, and to the latter its world-wide circulation will insure a proper recognition of their important scientific communications in the right quarter.

To the active and hard-working medical staff of the JOURNAL, some of whom assisted us with 'Pediatrics,' and are pioneers in this country of this branch of medical study, we tender our hearty thanks and a warm appreciation of their freely given efforts, to which the literary success of the undertaking is in large measure due. For the material results which have been obtained during the past year the publishers, printers, and their employés—who have displayed the recent records of work done at home and abroad in such a handsome setting, and who, one and all, have taken a personal interest in this venture—must be given due credit, to which they are so well entitled.

To other would-be workers who view the JOURNAL with a friendly eye, we will add that its columns are open to all who desire publicity for interesting observations; they can rest assured that their contributions will not be "buried"; and we invite them to come forward and assist us in making this periodical a storehouse of valuable information which will be a credit to the country, an example for other nations to follow, and a permanent memorial to British industry and research on a subject which is of vast and increasing importance to the national welfare.

Excerpta Puerilia.

Prevention of Cruelty to Children Act, 1904.—We may be excused for once again drawing attention to the various amendments of the 1894 Act as embodied in that of 1904, especially having regard to the following practice, described in a contemporary paper, which we are informed is still a custom in our large towns, though it is not of frequent occurrence :

"The records of the Mendicity Society reveal numberless stories of suffering child life . . . the street singer with the borrowed child is not uncommon. A police officer in the East End told an 'Express' representative that, quite as easily as in bygone days, children can be hired as 'draws' for perambulating beggars. The prices charged vary, but a baby can be obtained for as little as sixpence a day. There are other women, again, who use children out of arms to beg, and compel them, weak and half-famished, to tramp miles in their quest for charity."

This form of child suffering ought to be quite impossible for the future, as Section (2) sub-section (*a*) provides "That any person over the age of 16 years who causes or procures any child, being a boy under the age of 14 years, or being a girl under the age of 16 years, or having the custody, charge, or care of any such child, allows that child to be in any street, premises, or place for the purpose of begging or receiving alms, or of inducing the giving of alms whether under the pretence of singing, playing, performing, offering anything for sale, or otherwise, shall, on summary conviction, be liable at the discretion of the Court to a fine not exceeding twenty-five pounds or alternatively, or in default of payment of such fine or in addition thereto, to imprisonment with or without hard labour for any term not exceeding three months."

It may be as well to note that a proviso to this section sets forth clearly that the sub-section (*a*) does not apply in cases where children appear in charitable entertainments, etc., held elsewhere than on premises licensed for sale of intoxicating liquors, but if held on such premises, a special exemption in writing, under the hands of two justices of the peace, is necessary.

We therefore urge all medical men to make themselves fully acquainted with the provisions of the Act, which they can do for the small cost of twopence-halfpenny. We believe that it is in the power of the general practitioner more than any other person to entirely put a

stop to this form of street begging, without any trouble to themselves other than merely informing the local Inspector for the Prevention of Cruelty to Children, or, if more convenient, the corresponding secretary of the local branch of the N.S.P.C.C., as we are convinced that except in a very gross case of cruelty through exposure—when naturally the medical man would be willing to appear as a witness—there will be no need for the matter to become a case for the police-court; a warning will be sufficient to stop the practice in the individual case, so justifying the aim of the N.S.P.C.C., and the statement that the Society exists, not for the purpose of prosecuting persons for cruelty to children, but to prevent the possibility of its occurrence.

Abstracts from Current Literature.

Medicine.

Syphilitic coryza of the new-born (reprint of a paper in '*Revue d'Hygiène et de Médecine Infantiles*,' *June* 3, *No* 3, 1904).—**Paul Gaston.**—The author insists on the importance of "snuffles" or congenital syphilitic coryza. It is a serious condition, not only because it may lead to the death of the child, but also on account of the local rhino-pharyngeal troubles it leaves behind, which interfere with nutrition and growth. In his clinical description he calls attention to the fact that "snuffles" commences insidiously, and exists for some little time before it reveals itself. The premonitory signs are difficulty in taking the breast and in breathing. Another point is that the rhinitis may be localised at first to the posterior parts of the nasal cavities. Gaston distinguishes five form, viz.: (1) Anterior coryza; (2) posterior coryza; (3) subacute adenoiditis; (4) suffocating rhino-pharyngitis; and, (5) acute, subacute, and chronic rhino-pharyngitis. These need not detain us, as it is the microscopical part which is of special interest. The author describes in the first place what he has found in the early stages of a mild syphilitic coryza (catarrhal rhinitis). The characteristics are epithelial desquamation and superficial vascular congestion. In the deeper parts of the mucous membrane the arteries and veins are dilated and surrounded by a cellular infiltration, but nowhere do the sections give one the impression of peri-arteritis or of a neo-formation analogous to the infiltrated or circumscribed syphiloma. This is confirmed by an examination with a high power: no polynuclear leucocytes, no plasma cells. The infiltration about the vessels is slight. There is particularly no proliferation of the vascular endothelium, or at any rate it is scarcely to be made out. No micro-organisms. The picture is quite other in marked syphilitic coryza at its acme (streptococcal rhinitis). Here, again, no trace of syphiloma formation. The vascular congestion and dilatation are extremely well marked; but, again, there is little, if any, change in the vessels themselves; but, on the other hand, numerous micro-organisms, short rods,

diplococci, staphylococci, and streptococci. The gravity of syphilitic coryza arises from its localisation and its infectious nature, mainly due to streptococci. The author next deals at length with the numerous complications which follow in the train of "snuffles." These he has tabulated in the minutely analytical manner of our French colleagues. It is not possible in this place to go into the details of these complications. As to the diagnosis of syphilitic coryza, he emphasises once again the importance of this. Usually "snuffles" is the first manifestation of congenital syphilis, and needs careful watching and treating. As to local treatment, it is but too often neglected. The nasal passages must be attended to and kept as clear and clean as possible, following this up with antiseptic insufflations of powders such as iodoform and boric acid (iodoform 1 gramme, benzoin 3 grammes, boric acid 10 grammes—Lermoyez); or calomel (calomel 0·50 gramme, bicarbonate of soda 3 grammes, talc to 10 grammes). Peroxide of hydrogen solutions, etc., are also useful in fœtid cases. In an additional note, Laurens warns against syringing or irrigating in any way, and also points out the danger of toxic complications with perchloride of mercury, cocaine, etc. He insists on the good results to be obtained by the careful instillation of 4 or 5 drops of peroxide of hydrogen solution (12 vols. strength, diluted with 4 parts of water), three or four times a day, alternating with the use of sterilised vaseline oil. Laurens finds that the instillation of 3 to 4 drops of adrenalin hydrochloride, 1 in 10,000, in each nostril a few minutes before putting the infant to the breast sometimes answers. If it does not, the infant must be spoon-fed, or if needs be, the œsophageal tube must be employed. Gaston's instructive paper contains four plates, two of which are histological. There is also a sagittal section of the frozen new-born head to show the relations of the parts.

George Pernet.

The cardiac area in childhood ('*La Pediat.*,' September, 1904).—**B. Guido**, from his own observations, states: (1) Cardiac percussion in children should be light, trusting more to the resistance perceptible to the touch rather than to the ear. (2) In the very young the heart is very high (second space), its position and direction almost horizontal, the apex 1 to 2, or even 3, centimetres outside the mid-clavicular line. With increasing age the heart becomes lower (third space), and assumes a position and direction more vertical, the apex approaches the mid-clavicular line, and about the seventh year coincides with the nipple; subsequently it is found below and inside it. (3) From birth to the second year of life the heart undergoes rapid enlargement, then moderately increases to the ninth or tenth year, when it undergoes a further rapid development on account of the ever-increasing exigencies of the organism in response to the development of the genital system which is initiated at this age. (4) The area of absolute dulness which in the child is always relatively larger than in the adult should be investigated in every case, together with the area of relative dulness, this method alone giving reliable information. (5) Digital percussion is the most reliable method.

Vincent Dickinson.

Suicide in childhood ('*La Pediat.*,' August, 1904).—**A. Solaro**, in a review of this subject, considers the best prophylactic to be proper education—*i.e.* individualisation of instruction instead of the schoolmaster's rod and pedagogy in general. Children affected psychically should not be allowed to mix with the healthy ones. Of the causes, he mentions: (1)

Religiosity, very exceptional, owing to the absence of intense religious sentiment in children. (2) Education, which, though not of itself increasing the tendency to suicide, yet does so indirectly owing to dread of school, burdensome lessons, morbid ambition, and the strain of examinations. In Berlin during the period 1788–97 there was only one child suicide, in the next decade three, and in the decade 1812-21 there were 31. (3) Pauperism; a potent cause. (4) Psychic state; heredity has a marked influence, as has also "psychic infection," which in children is common. (5) Sex; more frequent in males, as in adults. (6) Age: the greater part occur between 11 and 25 years; very exceptional previously. (7) Occupation: out of 200 suicides 103 were pupils at "middle" schools, showing the influence of inability to fulfil imposed tasks, leading to morbid states of mind and dread of punishment; 44 out of 88 fathers belonged to the industrial classes, showing the influence of the struggle for existence on the minds of the children. (8) Season: notwithstanding the greater misery of the winter, the greater number of suicides occur in the spring; they are more common at the end than at the beginning of the scholastic year. (9) Special causes: fear of punishment, 58; bad reports, 28; ill-treatment, 18; illness, 12; lecture, 2; trouble, 5; chastisement administered, 25; love, 11; nostalgia, 1; discontent, 5; unknown, 35. (10) Pathology: In two cases there was atheroma of the arteries. Hanging and jumping from the window were by far the most common means in childhood; others were drowning, shooting, poison, stabbing, jumping under trains, and burning.

VINCENT DICKINSON.

Lobar pneumonia in infancy (*'Archives of Pediatrics,' September*, 1904, *p.* 641).—**J. L. Morse** analyses 118 cases admitted into hospital during nine years. Of these, 50 occurred in the first and 68 in the second year of life. Only 60 cases of broncho-pneumonia were admitted during the same period. In only 1 out of 77 in which a complete history was obtained was the disease ushered in by convulsions. Vomiting was mentioned in 7; a chill in none. Drowsiness, apathy, fever, and cough were frequent. Apparently the onset is not often acute. The percentages of the lobes affected were: right upper 17, middle 1, lower 16; left upper 14, lower 38. In 61 a whole lobe, in 40 a portion, and in 17 more than one lobe was affected. That is, in 86 per cent. only one lung was involved. The duration of the fever was most commonly seven days, rarely less than five or more than nine. The highest temperature was generally 103° F. to 106° F. Crisis occurred in 68·8 per cent., and was rarely associated with collapse. A pseudo-crisis was only noted in 9 cases. The usual pulse ratio was 150—170 (51·2 per cent.). Death did not occur unless the pulse rate was over 140. Above that rate it had little influence on the mortality. No case died with a respiration rate below 55, and three out of five, in which the rate rose to 90, recovered. The mortality was 26·3 per cent.—36 per cent. in the first and 19 per cent. in the second year, therefore nearly twice as fatal in the first year. In 23 out of the 31 fatal cases there was no complication. In most there was little or no resolution of the lung. Empyema 4, nephritis 1, meningitis 1, cardiac failure 1, thrombosis of longitudinal sinus 1, were causes of death in the other 8. To a certain extent the mortality varied with the amount of lung involved, but not with the portion affected. Complications noted were: empyema 9, serous pleurisy 1, otitis media 21, thrombosis of longitudinal sinus 1, pneumococcal meningitis 1 (fatal), marked meningeal irritation 3, acute nephritis 1, jaundice 1. The treatment

consisted of nursing and diet in 30 cases; anti-pneumococcic serum, without effect on the course of the disease, in 10; creasotal in 6, no apparent benefit; brandy in 70; strychnia in 30; spiritus ammoniæ aromatice in 12; digitalis 1; caffein 1; phenacetin 8; lactophenin 1. Cold, in various forms, was used in 28 cases. Tub baths at 80° F. to 100° F. were usually badly borne, and in 2 out of 8 caused serious collapse. Sponge baths at 80° F. to 90° F., or of alcohol and water at 100° F., were used in 5 cases, and fatigued the patients without benefit. Fan baths at 100° F. to 110° F. were used in 14, and in 11 did good. The cold pack was used in 1 case with good results. Cotton jackets and poultices were never used, and no applications were made to the chest. The writer concludes that the prognosis varies decidedly with the age of the infant, and to a certain extent with the amount of lung involved. It is good when the fever is not over 103° F., the pulse not over 140, and the respiration not over 55. The cases were under the care of Rotch, Wentworth, and the writer. EDMUND CAUTLEY.

Transmission of hereditary syphilis to the second generation (*'La Clinique Infantile,' October,* 1904).—**Edmond Fournier** reports on 116 families in which one or both parents had congenital syphilis. There were in these families 366 pregnancies, ending in abortion in 115 cases, and 174 infants died during the first years of life. Of the 192 survivors 31 only were healthy and 28 had definite syphilitic disease. The following conditions were found, in this order of frequency: infantilism with retardation of speech, cranial deformities, ocular lesions, convulsions, meningitis, idiocy, stigmata of degeneration. Fournier considers that these children can transmit syphilis to their descendants. The forms of active syphilis shown in the second generation were roseola, gummata, plantar and palmar syphilides, and ulcerations of the vulva, anus, etc. J. PORTER PARKINSON.

Primary tracheobronchial diphtheria (*'La Tribune Med.,'* 1903).—**Emile Sergent** and **Henri Lemaire** publish a case of this rare condition, the existence of which has been often denied. It occurred in a young girl, aged 21 years, who was taken with intense dyspnœa accompanied by recession above and below the sternum. She had no sore throat, coryza, or enlarged glands in the neck. Laryngoscopic examination showed the larynx to be of normal appearance but paralysed. Tracheotomy resulted in a copious elimination of false membrane and immediate relief. The bacteriological examination showed the diphtheritic character of the false membranes, one of which was 15 cm. long. In spite of vigorous antitoxin treatment she succumbed in six days from uræmia. The necropsy showed extensive false membranes over the whole bronchial distribution, with foci of broncho-pneumonia, while two large peritracheal lymph glands compressed both recurrent laryngeal nerves. A culture from the lungs showed the Klebs-Loeffler bacillus alone, and these were demonstrated also in the alveoli of the lung. The illness had begun eight days before admission into the hospital with signs and symptoms indistinguishable from bronchitis.
J. PORTER PARKINSON.

Involvement of the eyes in epidermolysis bullosa (*'The Brit. Journ. of Derm.,'* XVI, 1904, *p.* 225, and *'The Ophthalmoscope,'* II, 1904, *p.* 308.—**George Pernet**.—The patient was a boy aged 15 years, in whom, in addition to the bullous lesions usually met with in Epidermolysis bullosa (also called congenital pemphigus), the eyes were affected in a similar way to

the skin; that is, the superficial parts of the cornea could be made to slide over the underlying deeper parts. I considered the complication was unique in literature, as he had not been able to trace any other instance of the kind.

JEAN FERRAS (Luchon).

The curative value of lumbar puncture in chorea (*'Riv. di Clin. Ped.,' June,* 1904).—**G. B. Allaria** practised lumbar puncture in seven cases. A cannula of 2 mm. diameter was inserted between the fourth and fifth lumbar vertebræ, the patient lying horizontally on the left side. A local anæsthetic such as ethyl chloride was rarely necessary; the only symptoms noticed were slight and transient headache, and vomiting. The author divides his case into two series; in one the cerebro-spinal fluid issued in drops without force, and the other in which it issued under strong pressure. Of the first series, three cases, no improvement in the choreic movements was obtained; in the second series, four cases, more or less rapid diminution of the movements occurred, in one case, a girl of 16, being so marked that two hours afterwards she was able to put food into her mouth without difficulty, and after ten days left the clinic cured. The mechanism of the therapeutic action of lumbar puncture is the decompression caused by the abstraction of fluid and the elimination of toxins.

VINCENT DICKINSON.

Acute myocardial insufficiency (*'Archives of Pediatrics,' September.* 1904, p. 655).—**F. Forcheimer,** of Cincinnati, draws attention to the large number of acute myocardial insufficiencies which develop in connection with such diseases as scarlatina, diphtheria, rheumatic fever, septicæmia, typhoid fever, and pneumonia. He ascribes many cases of heart weakness during pubescence and early adult life to myocardial changes, especially interstitial ones, set up by these diseases in earlier life. In some cases the symptoms of insufficiency do not develop until after the primary disease is apparently over. The cause may be either a primary myocarditis or a secondary process following a degenerative change. The early signs are diminution in heart force and arrhythmia; then follow dilatation of the left heart, of the right heart, relative insufficiency of the valves, and enlargement of the liver. Sometimes the right heart is first affected. Tachycardia or bradycardia may be present. Diphtheria and influenza are the most common causes. The most essential point in the treatment is absolute rest. Symptoms, which throw an extra strain on the weakened heart, *e.g.* cough, should be attended to. Digitalis is often useful. Stimulants are almost always necessary. Special attention to convalescence and during this stage use may be made of Swedish movements, massage, etc. Strychnine may be used as a tonic. Nitro-glycerine should be avoided if there is any evidence of vaso-motor paralysis. For the latter condition camphor is reliable and caffein still more so. Forcheimer has found hypodermic injections of adrenalin of value, but they must be repeated every two hours, as the effects are transitory. Saline infusions, ice bags to the abdomen and abdominal massage help in the treatment of this form of paralysis.

EDMUND CAUTLEY.

Pathology.

Meningitis as a complication of the pneumonias (*'Rev. Mens. des Mal. de l'Enfance,' May,* 1904, *vol.* XXII, *p.* 193).—**Roger Voisin** publishes a valuable article on this subject. Clinically, there are all degrees of intensity

in the meningeal symptoms that may be met with in pneumonia, varying from some stiffness of the neck and rigidity of the limbs to repeated general convulsions and coma. These symptoms the writer describes in some detail. At autopsies the same rule holds; sometimes the meninges are coated with pus, much more commonly on the convexity than at the base; or, on the other hand, there may be some slight œdema and injection of the pia mater —a condition usually described as serous meningitis. The noteworthy facts are that on the one hand a purulent meningitis may be found when no symptoms have been evident, and on the other hand intense meningeal symptoms may occur, when only the slightest lesions are found post mortem. These latter cases were first attributed to *meningism*, a dynamic alteration in the functions of the meninges; later, since Dupre's work in 1894, the action of toxins has been held responsible. This opinion seemed to be confirmed by the absence of growth in cultures taken from the fluid, until 1897, when Lévi, in a case of serous meningitis from which no organisms grew, used the sensitive pneumococcic test of injecting the fluid into white mice, with the result that they rapidly succumbed to pneumococcic septicæmia. Lévi considered that serous meningitis was therefore an attenuated meningitis, but other writers have interpreted his results as showing that it is a hypervirulent meningitis, the cases dying before pus has time to be formed. **Voisin** has examined the fluid obtained by lumbar puncture in cases of broncho-pneumonia and lobar pneumonia. He states that the liquid is usually clear, but may rarely be cloudy, then indicating a purulent meningitis; the liquid is abundant, and may be under high pressure; the quantity of albumin is increased notably, the heat test being sufficient to demonstrate this; he was unable to confirm either René Mond's opinion that serum globulin is normally present, the increase in the albumin in meningitis being due to serum albumin, or Sabrazé's opinion that serum albumin is normally present in minute quantities, and is merely increased in meningitis; the percentage of chlorides is diminished, but not to the extent nor with the constancy that they are in tuberculous meningitis; leucocytosis was not common, and occasionally was of a lymphocytic nature; he agrees with Concetti and Percheron (*v.* abstract above) that a polynucleosis in a clear fluid is only found in tuberculous meningitis when very numerous bacilli are present. As regards organisms, he was struck by the fact that even in purulent meningitis, when they could be seen in stained films, they could not be grown either on cultures or in animals; streptococci seemed to be modified in cerebro-spinal fluid, so that it was often difficult to differentiate them from diplococci; he never found Pfeiffer's influenza bacillus, as other workers have. In short, in practically all cases of pneumonia evident changes were present in the meningeal reactions, and these changes, though of variable degree, could not be correlated with the intensity of the clinical meningeal symptoms. On the other hand, by Nissl methods, changes were found in the cortical pyramidal cells which appeared to vary in degree exactly with the clinical phenomena. The mode of infection of the cerebro-spinal fluid is next considered. Post mortem pus was found in the middle ear in over 75 per cent. of the cases; Netter has clearly shown that virulent organisms may exist in this cavity, and may infect the cranial cavity without ever producing purulent otitis. The nasal sinuses are another possible route. Nevertheless, for reasons that are not made clear, **Voisin** considers that the blood is the usual means of infection, but he cannot confirm Hutinel's view that meningitis of this origin is less virulent than that of otic origin.

In conclusion, the author claims that meningeal infection is almost constant in pneumonia in children, and that the termination will depend entirely on whether or not the cortical cells are affected by the poison.

A. Ernest Jones.

Acute tuberculous pericarditis with large hæmorrhagic effusion (*'Rev. Mens. des Mal. de l'Enfance,' August*, 1904, *vol.* xxii, *p.* 368).—**Richardière** and **Tissier** describe fully the case of a boy of ten who was brought to hospital after suffering from pain in the left side of the chest for a fortnight. He presented these signs: Heart's apex beat not perceptible; dulness from second to ninth rib, omitting Traube's space; friction about the third space (curiously enough sitting up made this louder); pulsus paradoxus; the lungs were healthy. In another fortnight the boy died, and at the autopsy a very intense and extensive pericarditis was found which under the microscope proved to be tuberculous. There were one and a half pints of a chocolate-coloured bloody fluid in the pericardium. Slight adhesions were present, but only posteriorly. An unsoftened tuberculous mass was present at the apex of the right lung, which was partly adherent to the parietal pleura. The case is a rare one, but not unique. Indeed, Virchow held that a bloody fluid in the pericardium was presumptive evidence of tubercle. It is interesting that, as the pericardium was not tapped during life, bleeding due to instrumental interference, or to rupture of vessels consequent on relief of pressure, can be excluded.

A. Ernest Jones.

Cerebral hæmorrhage in a boy of twelve (*'La Tribune Médicale,' August* 20, 1904).—**Gallavardin** and **Jambon.** The patient, five times choræic in five years, became suddenly apoplectic; after some hours of coma he remained paralysed on the right side, with aphasia. Seven days later was again apoplectic, followed by general contractures, Cheyne-Stokes breathing, etc. Two days later died comatose with hyperpyrexia. There was found in the left hemisphere a large clot which had a purulent centre, and in the right the centre of the hemisphere was destroyed by a large hæmorrhage, which had opened into the ventricles and extended to the pia mater. In the heart no murmur had been heard; there were large vegetations on the mitral valve which had caused infarcts of the spleen and kidney.

T. P. Beddoes.

Lumbar puncture and the diagnosis of tuberculous meningitis (*'Rev. Mens. des Mal. de l'Enf.,' February*, 1904, *vol.* xxii, *p.* 85).—**Percheron,** in an elaborate monograph, fully considers the value of lumbar puncture as an adjunct to the diagnosis of this condition. After considering the various points of technique in the procedure, which is universally considered to be harmless by those experienced in it, he deals at some length with the evidence that can be thus obtained. The mode of flow is more rapid than normal, owing to the increased pressure of the liquid, which may even spurt out. The colour of the liquid is often slightly yellow, from the presence of serum lutein, instead of being quite clear, and in the later stages the usual transparency is replaced by a cloudiness. The author attaches great importance to the characters of the coagulum that forms after standing. In tuberculous meningitis it floats in the middle of the liquid; it is translucent, with, perhaps, some whitish flocculi; it is of extreme tenuity, resembling a spider's web; when removed it forms a whitish or greyish mass, tough and very difficult to spread on a slide. In non-tuberculous meningitis

the coagula are tenacious, often of a yellow colour, adhering to the walls of the vessel, capable of being spread out more easily, and are composed of a very rich network enclosing cellular elements and micro-organisms. The author attaches no great value to the study of the tonicity, the freezing-point of the liquid, its toxicity, its agglutinating power, or to its permeability to iodides. The percentage of chlorides is diminished, as is the reducing power of the liquid. This latter may even be completely absent. The albumin, normally present in traces, is always increased in any meningitis; in addition to the normal globulin serum albumin may be demonstrated by Arthus's method. It has lately been shown that secondary infections are not very rare in tuberculous meningitis, so that the presence of organisms other than tubercle bacilli do not, as was once thought, exclude a tuberculous process. Tubercle bacilli may be found by microscopic examination after centrifugalisation, by inoculation of guinea-pigs, and by cultivation in special media. Authorities differ greatly in their estimate of the value of the first procedure, Marfan having only exceptionally found bacilli thus, whilst Pfandler found them in 70 per cent. of his cases. Percheron found them in seven of his sixteen cases. By inoculation, however, their presence may be demonstrated practically always. The cytological examination is that most usually practised. In non-tuberculous meningitis a polymorphonuclear cytosis appears early in the case, to give way later to a lymphocytosis as the case progresses towards recovery. In tuberculous meningitis there is lymphocytosis throughout, except in cases with very abundant tubercle bacilli, or with a secondary infection. All the above questions are gone into with great thoroughness, so that the paper furnishes an indispensable basis for further researches. A. Ernest Jones.

Status lymphaticus (*'Archives of Pediatrics,' July*, 1904, *p.* 500).—**R. A. Biechele** reports three fatal cases. (1) Female, aged 11 months: under treatment aged 6 months for entero-colitis, during which she had an attack of thymic asthma and several slight convulsive seizures. Rickets were well marked. The tonsils were large, adenoids present, superficial glands not much enlarged, and there was increase in dulness over the region of the thymus. After a slight fall she had convulsions for two hours, then thymic asthma for three hours, followed by a short period of coma, and then again convulsions until death, twenty-two hours after the fall. (2) Male, aged 22 months; always healthy until an attack of influenza of a mild type. On the second day of the attack he developed epileptiform convulsions and died four hours later. At the autopsy the tonsils were greatly enlarged, adenoids marked, rickets present, and the thymus weighed 52 grammes, filling out "the critical space of Grawitz," but not compressing the trachea. The bronchial lymph nodes and the spleen were enlarged. Peyer's patches were large and elevated, and the solitary follicles were very conspicuous throughout the large intestine. Mesenteric and retroperitoneal glands were also very numerous and enlarged. Microscopically, the thymus exhibited hyperplasia of lymphoid elements and degeneration of Hassal's corpuscles. Similar hyperplasia was seen in the lymphoid elements of the intestines, the mesenteric glands, and the spleen. The liver showed diffuse fatty degeneration and the kidneys a state of cloudy swelling. (3) Female, aged 13 months; always healthy except for periodic attacks of tonsillitis. Illness began with an attack of influenza. Next morning the child appeared bright, but restless. About twenty minutes after being seen she became convulsed and died during a third seizure shortly after. A partial post-mortem

examination revealed a large thymus, large tonsils, and adenoids, and a very extensive hypertrophy of the superficial glands. The child had been a mouth-breather since birth. There was no evidence of rickets, but the spleen could be easily palpated. Enlarged thymus may be the only thing found post mortem; it may weigh as much as 150 grammes. Biechele draws especial attention to the marked elevation of Peyer's patches and to the very distinct aggregation in the ileo-cæcal region. This condition is said by Ohlnacher to be characteristic. EDMUND CAUTLEY.

Surgery.

Treatment of chronic prolapse of the rectum by paragangline. (' *La Pediat.*,' August, 1904).—**L. Miserocchi** relates the case of a child aged 3 years, who had suffered since birth from a serious gastro-intestinal disturbance with prolapse, which for the last six months had become habitual at every action of the bowels, which were at times loose, at others constipated. He was treated ineffectually for some time by means of rectal suppositories, and was then ordered as an injection 50 drops of paragangline vassale in 200 grammes of water, morning and evening. After fourteen days, during which defæcation was performed daily, and with lessening pain, the absence of prolapse was noticed. The injections were continued ten days longer, and as there was no recurrence they were then omitted. During the twenty-four days of treatment the inflammatory condition of the bowel did not improve much, but was then cured by $1\frac{1}{2}$ grammes of sulphate of sodium given every morning. VINCENT DICKINSON.

Mercurial necrosis of the jaw (' *L'Echo Médicale du Nord*,' *October* 9, 1904).—**Jourdran.**—A girl aged 12 years had four injections of calomel (amount not stated) in a fortnight, when in hospital in Madagascar for syphilis. Ginvigitis, salivation, difficulty of mastication and speech followed, with hæmorrhagic phenomena. A large number of teeth were lost, and a large part of the inferior maxilla came away; cicatricial adhesions formed round the mouth, reducing it (as shown by photographs) to a mere gap. T. P. BEDDOES.

Separation of the epiphyses (' *Gazette des Hôpitaux*,' *October* 8, 1904). —**Kirmisson.**—These are most common from 12 to 15 years and decrease up to the 25th year. There are usually superadded fractures of the displaced bones. The separation may occur in the middle of the epiphyseal cartilage, or this may remain adherent to the bone, of which a layer intervenes between the cartilage and the line of separation. The rupture of the periosteum and its stripping off favours return of displacement, and by intervening between the parts hinders reduction. Poland's classification of relative frequency is adopted—the lower extremity of the femur, the lower end of the radius, the upper then lower ends of humerus, the lower and upper end of tibia. The crepitation is fine and equal. Blood may collect in the joint, gangrene may occur from rupture of vessels at the time of injury, or from the displaced bones pressing on the vessels. Separation of the lower end of the femur is best reduced with the knee flexed. The upper end of the shaft of the humerus is drawn upwards, forwards, and inwards. In dislocations the rounded head of the humerus is large, with a gap under the acromion. Resection of the humerus may be required for reduction or vicious union. Reduction is easiest with the limb raised abducted with

traction on the arm. At the lower end of the radius the displacement may be considerable, together with pain and swelling near the joint; movement may be normal, crepitation absent, and the injury may require a skiagram to diagnose accurately. Separation of the lower epiphysis of the humerus is rare—Poland only records six cases—because it is narrow, passing below the condyles, and on the outer side passing obliquely downwards and inwards. Separation of epitrochlear may occur, as it does not unite till the seventeenth or eighteenth year. In children fracture of both bones of the forearm occurs some distance from the wrist. The upper epiphysis of the femur may be separated by injury, or by muscular contraction and may pass unrecognised for a time; increasing deformity simulates coxa vara, best treated by extension; cases seen late may require open treatment. In one case, seen six weeks after injury, the neck was drawn up, there was no formation of fibrous tissue; the part was removed after resection of the round ligament; seen twelve years after, the result was perfect. These separations may be followed by shortening. Poland records eighteen after separation of the lower end of the radius. But as the injuries often occur towards the end of the period of bony growth and compensatory increase of other centres may occur, the shortening is not often complained of. T. P. Beddoes.

Tubercle of the œsophagus (*'Journ. de Médecine de Bordeaux, September* 4, 1904).—**Rocher.**—A girl, aged 12 years, swallowed caustic potash six months before admission into hospital, when she weighed 18 kilos. (39·6 lbs.); temperature 35° C. (95° F.). She was so weak that she could not move in bed. Serum was injected. A fine bougie was with difficulty passed and retained till next day, when a larger one was employed and retained till the evening; she could then drink better. The bougie was increased to a No. 15, being left in two or three hours. The weight increased 3 kilos. (6·0 lbs.) in three weeks, and went up to 33 kilos. (72 lbs.). The patient herself could in the course of an hour pass a No. 24 or 25 bougie into the stomach. Dilatation was practised every four or five days. Fourteen months after admission she coughed up a wineglassful of blood. A cough began and weight was reduced to 25 kilos. (54 lbs.); one lung was affected primarily; in five months more both lungs were affected and caused death, the permeability of the œsophagus being unaltered. Post mortem the ileo-cæcal glands were enlarged. The lungs contained tubercles, with extensive pleural adhesions. Round the œsophagus were many large glands adherent to it and the left bronchus; some glands were pigmented. The stricture was in the middle part of the œsophagus, and here there was extensive ulceration. References are given to twenty-five other cases of tubercle of the œsophagus. T. P. Beddoes.

A case of pneumococcic pyæmia (*'Lancet,' Oct.* 8, 1904).—**A. T. Davies** and **W. Langdon Brown**. A girl aged 8 years had been ill for two days. She was anæmic, with rapid pulse and respiration. The temperature was 102·4° F. On examination she was found to be suffering from broncho-pneumonia, peritonitis, and arthritis, the latter involving the right knee-joint, which was swollen and tender. Five days later the patient showed signs of improvement, but after the lapse of another week she did not appear to be so well. Evidence of empyema involving the right side was now made out, and the pus was found to contain diplococci staining with methylene blue and by Gram's method. The abdomen was distended and tender and showed signs of free fluid, while the knee was still swollen

and painful. A blood count gave 4,000,000 red corpuscles and 21,000 leucocytes per cmm. The seventh right rib was resected, 20 ounces of pus removed, and a drainage-tube inserted. The signs in the chest now rapidly cleared up. Five days later the knee-joint was explored. It was found to contain four ounces of pus, which showed diplococci similar to those obtained from the pus in the chest. The right hip-joint now began to swell, but an exploring-needle gave a negative result. About a fortnight later the abdomen, which had been improving, showed signs once more of free fluid. Sickness, with feeble and rapid pulse, now troubled the patient, while a few petechiæ appeared on the abdomen. Eight ounces of pus were removed by a Southey's tube, and later laparotomy was resorted to, resulting in the evacuation of about three pints of pus. From this time the patient began to improve and to put on flesh. Convalescence was tardy, and during this period the patient had a slight vaginal discharge, and a return of œdema round the knee-joint. Six months later she was in excellent health, and showed no ill effects from the disease except a flexed and ankylosed knee. Liability to secondary pneumococcal infections seems to be greatest in early life. Probably, while the local lesion is sufficient to cause death in older persons, the more resistant young can tolerate an extensive invasion before succumbing. In the present case probably the infection occurred through the lung. As a direct sequel to pneumonia or broncho-pneumonia we may regard peritonitis as decidedly rare. Most of the recorded cases show a somewhat chronic course, a tendency to relapse, and a tedious convalescence. Arthritis was formerly regarded as a rare pneumococcal lesion. It usually appears during the height of the disease, and it usually implicates the synovial membrane. The knee is the joint most frequently attacked. The vulvitis in this case occurred after the opening of the abdomen, and was due to the discharge running down on to the vulva. It yielded to simple antiseptic lotions, and was, therefore, in all probability, due to accidental contamination and not to any deep-seated cause. JAMES BURNET (Edinburgh.)

Symptomatic Metatarsalgia in Paralytic Talipes (*'Congrès de Gynécologie, d'Obstétrique et de Pédiatrie,' Rouen, April*, 1904).—**Péraire** read a paper on this condition. He says that the pain occurs on walking, on putting on or taking off the boot; the site is always over the anterior extremity of the first metatarsal only, which shows no swelling; the symptom only occurs in talipes valgus, equinus, and equino-valgus; the anatomical lesion is a deformity of the head of the bone, a condensing ostitis, and often there is a serous bursa over this. It is easy to distinguish the condition from Morton's metatarsalgia. The symptom is at once remedied by curing the deformity by the usual surgical principles. **Broca** did not admit the terminology used by Péraire. The lesions shown were those of a hygroma.
A. ERNEST JONES.

Intussusception cured by sloughing (*'Archives of Pediatrics,' July*, 1904, *p.* 494).—**J. M. Snow** reports a case of a baby, aged 7 months, who had severe symptoms simulating an ileo-colitis for sixteen days. At the end of this period the abdomen was distended and tympanitic, but no tumour or tenderness was detected. During examination gas, mucus, and fæcal matter were passed, followed by protrusion of a mass like ragged membrane from the anus. Next day this protruded mass, consisting of necrosed intestine about six inches long, was removed by pulling it down and passing a ligature round the living tissue above. Spontaneous cure by gangrene and elimination of the dead intestine was much more common formerly than it

is now, when cases of intussusception are more readily diagnosed. Such a cure is least frequent in infants under a year old; for they die of pain, inanition, exhaustion, and shock too early for the process of separation to be complete. Snow could only find four other recorded cases, viz. a baby aged 12 months (Henoch); boy, aged 7 months (Beeston, 1893); girl, aged 7 months (Harrison Cripps, 1882); baby, aged 6 months (Stimmeyer, 1894). EDMUND CAUTLEY.

A case of extraction of an intubation tube from the right bronchus.—**McCosh** relates the case of a child, aged 14 years, on whom thyrotomy had been performed in 1895 for multiple papillomata, and simultaneously tracheotomy at the level of the third and fourth tracheal rings; the cannula was continuously worn until 1900. Examination at this date showed that the lumen of the larynx was entirely obliterated for the space of $1\frac{1}{2}$ cm., and the epiglottis was bound down by scar to the upper inlet. By two operations the channel was restored and the epiglottis freed, a rubber tube being fixed in the canal. Later the raw surfaces were covered with epithelial grafts, and lastly the front wound was closed. After two months the rubber tube was exchanged for an intubation cannula, and this was worn for two years uneventfully. A forcible inspiration suddenly displaced it into the right bronchus. This accident was followed by cyanosis and bloody expectoration. Ineffectual attempts were made to extract the tube through the enlarged tracheal fistula; about sixty hours after the accident the trachea was split right down to the sternum, but attempts to extract were then accompanied by serious venous hæmorrhage from the trachea. The condition appeared desperate, but the large roughened tube was eventually dislodged, and the hæmorrhage then soon ceased. The tracheal wound was then closed except for an opening sufficient to accommodate a tube; the latter was discarded in fourteen days. Since then the patient breathed easily through the new-formed larynx, and the voice was sufficiently loud to be heard in a large room. K. W. MONSARRAT (Liverpool).

Reviews of Books.

RECHERCHES SUR L'EPILEPSIE, L'HYSTERIE ET L'IDIOTIE; COMPT-RENDU DU SERVICE DES ENFANTS IDIOTES, ÉPILEPTIQUES ET ARRIÈRES DE BICÊTRE PENDANT L'ANNÉE 1902. Edited by BOURNEVILLE. (Bureaux du Progrès Médical, 1903.)

The appearance of this volume, the twenty-third of its series, is a reminder of yet another department of medicine in which the foreigner is relied upon for all progressive research. It is a book that has no counterpart in England, for the simple reason that such original investigation is not being carried out, except in the most spasmodic and unmethodical manner. The great gift that the workers at the Bicêtre appear to possess is that of enthusiasm; this is probably inspired by their chief, Bourneville, whose capacity for work is apparently unlimited; it is evident in every page of this book, from the wearisome cataloguing of washing garments to the most detailed description of facial characteristics.

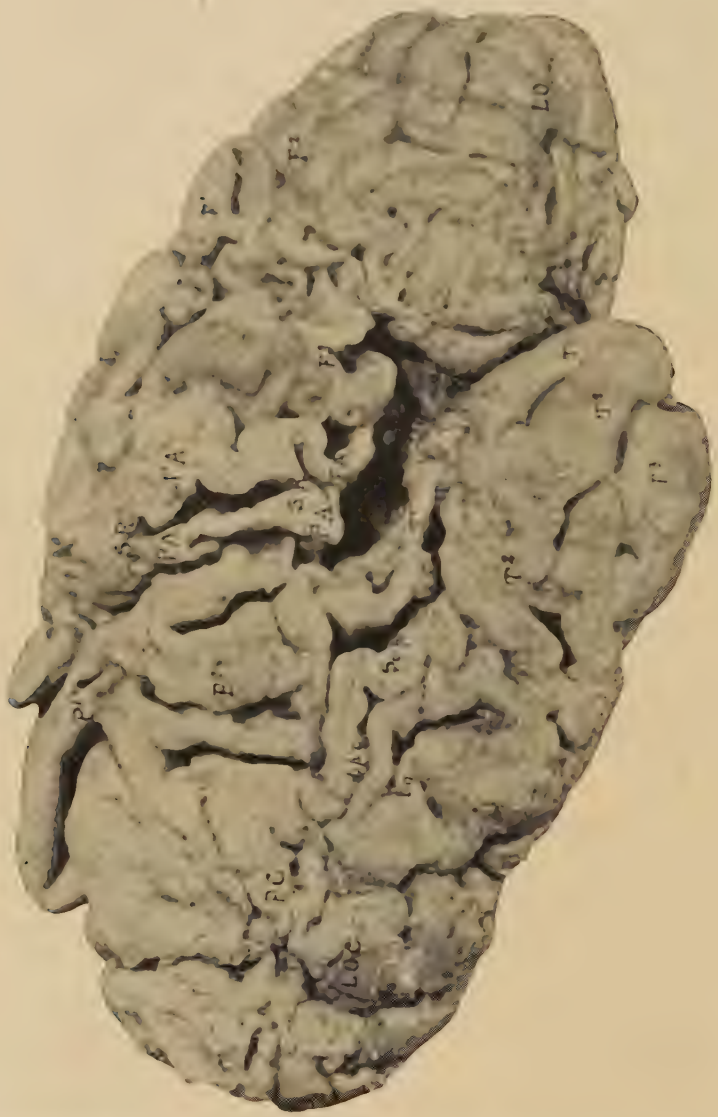
Cretin, aged 35 years, after treatment.

Cretin, aged 24 years, before treatment.

Diplegic contracture.

The volume is divided into two halves; it contains thirty-eight figures and nine plates.

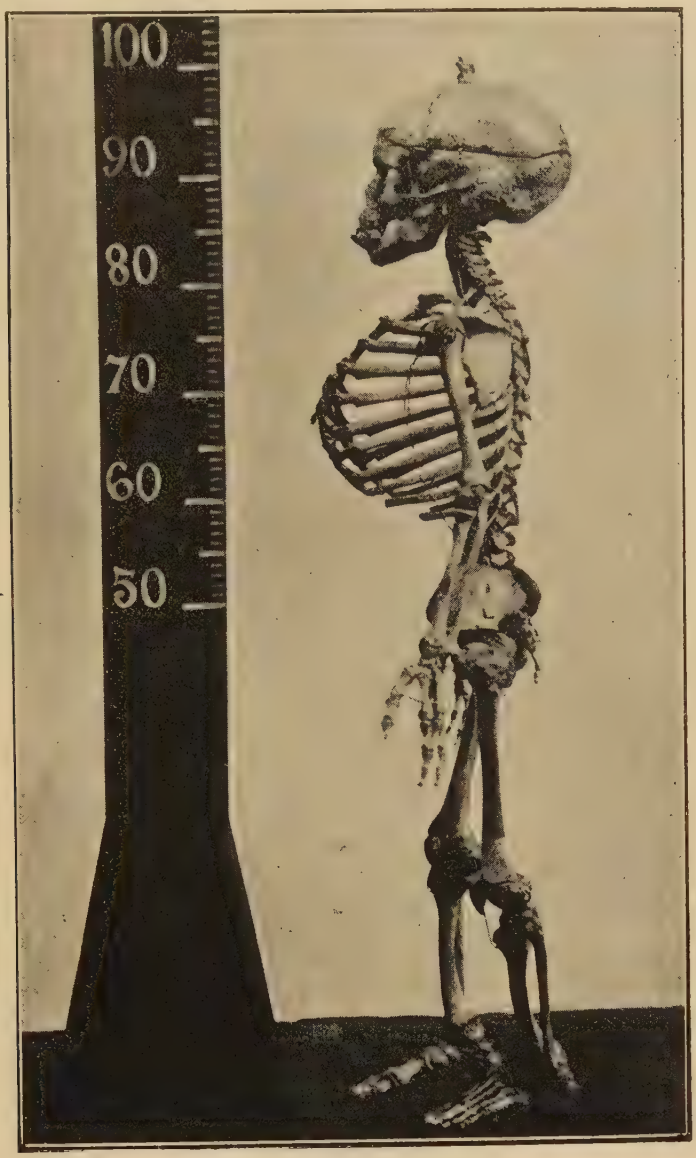
The first part is concerned with the administrative affairs of the asylum.



Right hemisphere of diplegic idiot.

The separation of the different varieties of imbecile and idiot children is discussed, and the immense importance of early segregation, with the organisation of proper training classes, is insisted on. M. Bourneville would severely condemn our English system by which we not only do not

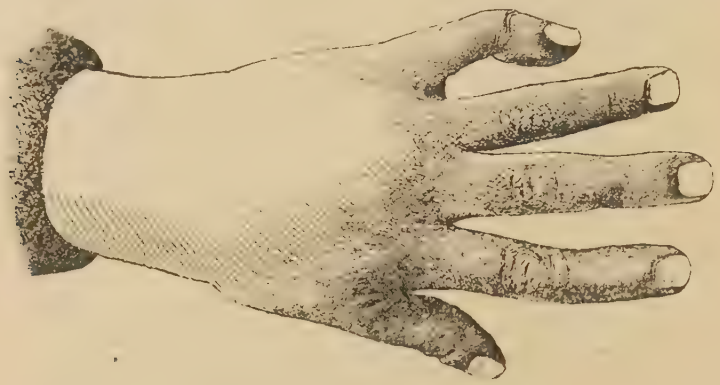
encourage segregation before the age of five years, but actually do not permit it. The remarkable results here detailed that follow the early training



Skeleton of cretin, aged 36 years.

of apparently hopeless cases will raise the greatest astonishment in one who is only accustomed to the English way of doing things. Even with such a

difficult symptom as incontinence in idiots, various training methods have produced most beneficial results. Later on toilet exercises are taught; no detail is too trivial to be overlooked, so that the net conclusion seems to



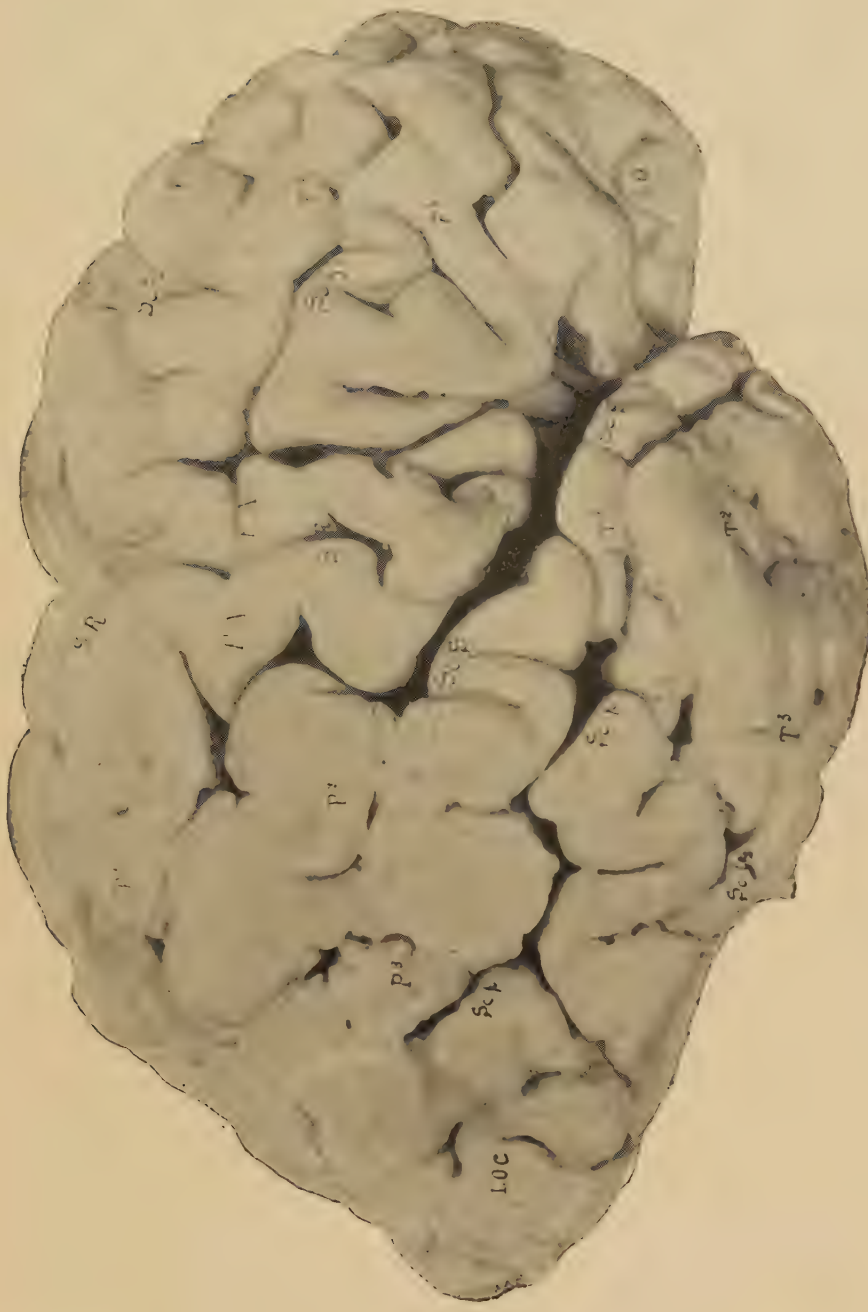
Hand of microcephalic idiot.

have been reached as if by magic. Respiratory and other movements are similarly taught with the greatest patience, and the whole system of medico-

Two brothers with family type of spasmodic diplegia.

pedagogy is here expounded. The *personnel*, population, movements, and general statistics of morbidity and mortality are narrated.

The second part is entitled "Clinique, Thérapeutique et Anatomie Patho-



Right hemisphere of diplegic idiot

logique." It consists of twenty-four memoirs, some of high value, written by members of the asylum staff. A feature of this part of the book is the illustrations, some of which are reproduced. From the different memoirs the following points are selected as being of especial interest. Phillippe and Oberthur give the results of examination of the brains of two Mongolian idiots, confirming the findings they had announced a year or two previously. A special discrete form of cortical meningo-encephalitis existed, affecting especially the most superficial layer of tangential fibres; the cortical cells escaped. Two other Mongols are described fully from a clinical aspect by Bourneville. He also has an article on the relation of parental alcoholism to epilepsy; the fallacies, however, in no wise differ from those seen in his previous writings on this subject. The same author describes in detail a special form of hand deformity observed in microcephalics; he promises a memoir later on the different varieties of hand deformities met with in idiots.

Attention is drawn by Bourneville, in another article, to scoliosis as a symptom of myxœdema and cretinism; reference is made to Chipaults' recent announcement of the discovery of this occurrence, and it is pointed out that for some fifteen years it has been recognised by various neurologists in their writings. Crouzon gives a useful summary of the technique employed in the elicitation of certain reflexes, confining himself to the better known ones. Bourneville publishes, in a valuable memoir of fifty pages, a complete history of a cretin who was under continuous observation for twelve years. Puberty never occurred, although he lived to the age of thirty-six. A detailed description of the skeletal changes is given, this being the first one on record; the main point brought out is the disproportion between the periosteal growth and the epiphyseal. A chemical analysis of the skin and a histological study of the brain are also added. A case of congenital hereditary partial canities is recorded, with some interesting remarks on this rare condition. Several cases of bleeding into the skin and mucous membranes during epileptic attacks are recorded, and their relation to ecstatic stigmata discussed. Bourneville adds 106 observations to his previous extensive statistics bearing on consanguinity in relation to the production of nervous affections, a *rôle* to which he attaches but little importance. Bourneville and Crouzon relate two cases of family spasmodic diplegia, and review the literature thereof. In the post-mortem examination of one of the cases, bilateral cerebellar atrophy was the most noteworthy feature.

In conclusion, this volume well maintains the reputation gained by its predecessors, and we can commend it to anyone who wishes to gain an insight into the work that is being done at the present time in imbecility and idiocy.

A. Ernest Jones.

The Sterilisation of the Hands: A Bacteriological Inquiry into the Relative Value of various Agents used in the Disinfection of the Hands. By Charles Leedham-Green, M.B., F.R.C.S. Pp. 102. Publishers: Simpkin, Marshall, Hamilton, Kent & Co., London. 1904. Price 2s. 6d. net.

It is somewhat curious how little work has been done in England on the direct investigation of the subject of hand sterilisation, and Mr. Leedham-Green is to be congratulated on having stepped into the breach so effectively as he does in this volume. In this matter many, instead of basing their

technique upon research, have been content with very uncertain foundations, and in discussion have upheld their practice solely on that very elastic and uncertain term, "satisfactory results." Hand sterilisation is a question which lends itself to exact investigation by laboratory experiment, and in view of this there is no excuse for the substitution of patients for test tubes, and of arguments based upon clinical results for those derived from bacteriological inquiry. Mr Leedham-Green's researches cover practically all the recognised methods of cleansing the hands which have been recently recommended. His method of investigation is an exacting one, and his results are recorded in a rational and striking manner. The value of a research in which all the different methods are submitted to a uniform test is obvious; it almost eliminates the personal equation and enables one to arrive at conclusions as to the true relative value of these methods. These conclusions may be summed up under three heads: (*a*) That a surgeon who demands that his hands should be uniformly bacteriologically sterile must wear impermeable gloves; (*b*) that provided the cosmetic condition of hands is good they can be sterilised with a fair degree of reliability; (*c*) that the use of dilute alcohol as an essential item in the process gives results which are much superior to those obtained by any other method hitherto suggested in which it is not employed. The particular modification of the alcohol-sublimate method which Mr. Leedham-Green recommends is one in which a 70 per cent. sublimate alcohol (1 in 1000) is substituted for the 1 in 500 watery sublimate solution of Fürbringer's method. Dilute alcohol has a marked bactericidal action, but its effectiveness also depends upon its property of hardening and preventing the detachment of the superficial cells of the epidermis. There are several matters of much practical importance dealt with in this book, in addition to the record of experiments; in particular must be noted the section on the duration of the sterility of a disinfected hand, and that on time as a factor in diminishing the infectivity of the hands. Mr. Leedham-Green's work has extended over a considerable number of years; it is work which has called for much patience, but it is well worth all the time he has spent on it, and deserves the thanks of all operating surgeons. K. W. Monsarrat (Liverpool).

Some Disorders of the Spleen (The Lumleian Lectures for 1904). By Frederick Taylor, M.D. J. & A. Churchill, London, 1904. Price 3*s*.

We do not share the pessimistic forebodings that assailed the lecturer in his introductory remarks—the preliminary stage fright which often heralds a notable success, as in the present instance.

Dr. Frederick Taylor deals with his subject from the clinical and coarse anatomical standpoints, and he has drawn largely on the post-mortem records of Guy's Hospital, his own clinical observations, and on the published observations of others.

The first lecture comprises capsulitis; enlargements from various causes, in which he demonstrates that two thirds of his material was of an infective or microbic origin; atrophy, mostly associated with new growths in the body; new growths; infection as a cause of enlargements; phthisis in which the majority of examples were not lardaceous; infective endocarditis; histology of the spleen in infective processes; cirrhosis and splenomegaly; disorders of the blood; and, in conclusion, an enumeration of a collection of cases of

splenomegaly difficult of diagnosis, dependent upon a variety of causes, together with the blood-counts of the patients.

Lecture II opens with a further record of cases of doubtful origin, and passes to a description of splenic anæmia, of which he gives numerous clinical illustrations and a review of the condition of the spleen, the cause of the histological changes in that organ, together with a variety of hypotheses as to the relationship of the anæmia to the splenomegaly. Banti's disease is next discussed, and the importance of obtaining the early history in such cases is dwelt upon, seeing that alcoholic cirrhosis may be mistaken for that disorder. The lecture concludes with an account of the spleen in association with pernicious anæmia.

Lecture III deals with anæmia pseudoleukæmika infantum at some length, with a critical survey of the present state of our knowledge and the deductions which have been drawn by various writers on their own observations. Hodgkin's disease, with its occasional passage into lymphæmia, is dwelt upon, as also the clinical difficulty of distinguishing the glandular hyperplasia from tuberculous adenitis. Leukæmia, chloroma, and primary and secondary anæmias are adequately treated.

In conclusion, Dr. Frederick Taylor considers that the spleen is more sinned against than sinning, and that it is rarely responsible for the lesions which it suffers or for the complaints with which it is associated.

This valuable monograph should be in the hands of every practitioner who wishes to keep abreast of the march of knowledge on the behaviour in disease of an organ to which increasing attention should be directed and concerning which more information is required.

Preparations.

Virol (Virol, Limited, 152—166, Old Street, London, E.C.) Virol is a carefully prepared laboratory preparation consisting of the proteids, fats, and salts of beef and eggs, beef marrow, and extract of malt of high diastatic power. The fats in the preparation are minutely divided, with the result that a most perfect emulsion is obtained. Its keeping properties are well known, a result which has been obtained without the addition of chemical preservatives. It is a honey-like preparation of a pleasing taste, and children take it readily. It will be found of value as a nutrient in athrepsia and as a blood-former in a variety of anæmic conditions in infancy and childhood.

Phillips' Milk of Magnesia (MgH_2O_2) (the Charles H. Phillips Chemical Company, 14, Henrietta Street, Covent Garden, W.C.). There are certain practical points which recommend this preparation of magnesium: thus, it contains no carbonic acid; it is highly antacid; it is pure magnesium, in permanent solution; it is perfectly miscible with other fluids; it is tasteless and odourless; it is an efficient mouth-wash and dentifrice. When magnesium preparations are indicated Phillips' milk of magnesium should be prescribed in preference to other well-known salts.

Erratum.—Page 497, line 21, November issue. Liquor strychninæ ʒij. should read Liquor strychninæ ♏ij.

INDEX.

Abasia, hypnotic suggestion in a case of, 383
Abdomen, tumour occupying left half of the, 310
Abdominal case for diagnosis, 72
— symptoms in Henoch's purpura, 38
Ablepharon, double, 523
Abnormalities, see under *Congenital*
Abrahams (B.), lobar pneumonia in children, 150
Achondroplasia, 94, 107, 311
— antiquity of (G. Pernet), 7
— fœtal, 324
Acromial reflex, 285
Act, Cruelty to Children, 550
— Employment of Children, 43, 224
Actinomycosis of the ear, 469
— of the tonsils, 384
Adenoids, rash following removal of, 227
— remarks on, 374
— supplementary measures after the removal of, 277
Adolescence, albuminuria of, 183
Albuminuria of adolescence, 183
Alcohol and children (George Carpenter), 419
Allan (A. P.), transmission of tuberculosis by milk, 146
Amaurotic idiocy, non-semitic, 142
Ambidexterity, 223
— its advantages (J. Jackson), 418
Ambidextral Culture Society, 175
Amentia, 100, 141
— relations of epilepsy to (A. F. Tredgold), 291
Amputation, intra-uterine, of three extremities, 362
Anæmia, chorea and, 461
— treatment of, by iron-vitellin (George Carpenter), 349
— two cases of, 261
Anæsthesia, death under, 189
Anæsthetic, "ethyl chloride" as a general (J. H. Chaldecott), 63
Angiosarcoma, secondary, of lung, 164
Appendicitis in children, 278
— discovered by rectal examination (D. McKenzie), 542
Arm, congenital absence of, 120
Armstrong (H.), comparative mortality of breast-fed and hand-reared infants, 115
Arsenic, herpes zoster and bullous eruption from administration of (J. H. Sequeira), 158
Arterial tension, modification of, in pneumonia, 237
Arthritis, chronic, tenosynovitis, rheumatism, etc., in a girl aged 10 years, 462
— gonorrhœal, secondary to conjunctivitis in a new-born child, 522
— tuberculous, in the young, 332
Ascarides, note on toxicity of, 229
— lumbricoides, suffocation due to, 328
Ascites in tuberculous peritonitis, diet in, 381
Ashby (H.), case of hydatid cyst of brain, 51
Atrophy, progressive muscular, of the family type, 362
— reflex, of articular origin, 325
Automatism, case of, 215
Axilla, congenital lymphatic cyst of, 276

"Babeurre" for feeble children, 287
"Babies," M. Corelli on, 223
Babinski, fan sign of, 284
Bacillus coli, action of the saccharomyces cerevisæ on the, 473
— cystitis due to, 331
— intoxication by, influence on nerve ganglia of heart, stomach, and intestines, 46
Barendt (F. H.), common facial lesions and infection, 210
Barley, Robinson's patent, 98
Barlow's disease, 464
— — blood in a case of, 382
Bed-wetting, see *Enuresis*
Benedict's inferior syndrome in poliomesencephalitis of Wernecke, 426
Bibliography, see *Literature*
Bidwell (L. A.), Gonorrhœal salpingitis in a child aged 6 years, removal of tubes, 435
Bile-ducts and gall-bladder, congenital dilatation of, 478
Bladder, inflammation of, see *Cystitis*
— irritable, in girls, 233
— stone in, see *Calculus, Urinary*
Boarding out of pauper children, 515
Boats, canal, child life in, 83
Bothriocephalus latus in a girl aged 4½ years, 230
Bovine tuberculosis, see *Tuberculosis, transmission of*
Brain, abscess of, otitic, 474, 525
— action of tubercle bacilli on, 382
— degeneration of, progressive, 163, 506
— endothelioma of, with chronic hydrocephalus (W. C. Chaffey), 195
— hæmorrhage in a boy aged 12 years, 565

Brain, hydatid cyst of (H. Ashby), 51
— surgery of, in congenital mental defects, 384
— tumour of, loss of tendon reflexes in, 285
— see also *Amentia, Encephalitis*
Branchial fistulæ, 164
British Journal of Children's Diseases, 554
— — — Princess of Wales and the, 122
British Medical Association at Oxford: lack of a Children's Section at, 410
Bromide rash in an infant, 505
Bronchi, foreign body in, extraction, 231, 476
Bronchus, right, extraction of an intubation tube from, 570
Bullous eruption, etc., from administration of arsenic (J. H. Sequeira), 158
Burnet (J.), association of chorea with tænia solium, 147
— some of the less commonly recognised manifestations of rheumatism, 392
Burrows (H.), case of Henoch's purpura in which laparotomy was performed, 28
Buttermilk as food, 89
— for feeble children, 287

Calculus, renal, nephro-lithotomy (J. P. Parkinson and D. Drew), 441
— urinary, treatment of, in children (D. Drew), 305
Cameron (Sir C.), schools at Folkestone, 374
Campbell (H.), evil effects of too soft diet for children, 373
Canal-boats, child life in, 83, 514
Capillaries, see *Pulsation*
Caries, tuberculous, of upper dorsal spine, 75
Carless (A.), some cases of lymphangioma, 56
Carpenter (George), alcohol and children, 419
— capillary pulsation in urticarial wheals, 309
— congenital cysts of the lung with dextrocardia, 160
— gonorrhœal inflammation of uterine appendages in a girl aged 3½ years, detected by bimanual examination, 437
— herpes zoster extending to the finger-tips, 545
— myocarditis, uncomplicated, in a girl aged 8 years, 515
— treatment of anæmia in children by iron-vitellin, 349
Cartilage, diseases of, see *Achondroplasia*
Castration, ossification of the epiphyses and, 383
Cataleptoid state due to cortical insufficiency, 462
Cattle, see also *Tuberculosis, transmission of*
Cautley (E.), congenital hypertrophic stenosis of pylorus, 10, 37
Cephalhæmatomata in new-born, 207
Cerebro-spinal fluid, loss of, from a wound of the dura mater, 432
— — of sick children, chloride of sodium in, 430
— — tubercle bacilli in, means of discovering, 234
— form of congenital syphilis, 461
Chaffey (W. C.), case of endothelioma of brain with chronic hydrocephalus, 196
Chaldecott (J. H.), "ethyl chloride" as a general anæsthetic, 63
Child Employment Act, effects of, 43, 224
"Child slaves," 220
— study, at Folkestone Congress, 370, 411
Children, canal boat, 83, 514
— care of, 321, 322
— criminal, 138, 221, 322
— diseases of, study of, 86
— milch cows, and, in Great Britain, diminution of, 132
— places of detention for, 322
— poor, care of in France, 134
Chloride of sodium in cerebro-spinal fluid of sick children, 430
Chlorides in diet, exclusion of, in ascites, etc., 381
Chloroform-poisoning, delayed (H. J. Stiles and S. McDonald), 262, 401
Chorea, acute fatal, with hæmorrhagic pericarditis, 287
— anæmia and, 461
— associated with tænia solium (J. Burnett), 147
— curative value of lumbar puncture in, 563
— pseudo-meningitis in the course of, 461
Cicatrix over mastoid, softening of, in course of scarlet fever, 526
Cigarettes and cigars, see *Tobacco*
Cirrhosis of the lung, 74
Clarke (J. J.), case of congenital coxa vara with associated deformities, 248
Clarke (J. M.), case of cured hydrocephalus, 503
Cleft palate, ill-developed lateral incisor tooth as a forerunner of (R. C. Lucas), 483
— — treatment of, plea for operation in early infancy, 476
Clitheroe school children to be medically examined, 272
Colon, congenital dilatation of, 262
— pathology of congenital megacolon, 287
Colour-sense in infants, 47
Congenital abnormalities, hereditary bias in, 339, 342
— abscess of left arm, 120
— coxa vara with associated deformities (J. J. Clarke), 248
— cysts of lung with dextrocardia (George Carpenter), 160
— — in neck (J. Marshall), 69

Congenital deformities, cases of (H. E. Harris), 502
— — of the face, etc., 362
— — multiple, 215
— diaphragmatic hernia, 479
— — two cases of (S. Gilford), 536
— dilatation of the bile-ducts and gall-bladder, 478
— — of the colon, 262
— dislocation of 5th cervical vertebra, 120
— — of hip, 95
— — — Lorenz, method in, 363
— elevation of the scapula, 278
— goitre, 476
— heart disease, 509
— — with dysphagia, 37
— hypertrophic stenosis of pylorus, 95, 331, 384
— — — (E. Cautley), 10, 37
— — — (C. T. Dent), 16, 38
— laryngeal stridor, 379
— lymphatic cyst of axilla, 276
— megacolon, pathology of, 287
— occlusion of the œsophagus, 333
— proptosis and meningocele, 260
— staphyloma of the cornea, 238
— stricture of œsophagus, 362, 364
— — — (B. M. H. Rogers), 390
— syphilis, cerebro-spinal form of, 461
— trophic œdema (O. Grünbaum), 531
— word-blindness, 521
Conjunctiva, pemphigus of, 228
Conjunctivitis in a new-born child, gonorrhœal arthritis secondary to, 522
Constitutio lymphatica; lymphatism (G. Peacocke), 187
Corelli (Marie), on babies, 223
Cornea, congenital staphyloma of, 238
Cortical insufficiency, cataleptoid state due to, 462
Coryza, syphilitic, of new-born, 559
Cows, hygiene of, 76
— milch, in Great Britain, 132
Coxa vara, congenital, with associated deformities (J. J. Clarke), 248
Craniotomy for tubercle, 474
Cretinism, 106
— thyroid treatment in, 380
Crime, relation of infantile insanity to, 138
— see also *Murder*
Criminal instinct, 221
Criminals, juvenile, 322
Croup, complicating measles, 241
— intubation in, 226
— operative intervention in, 335
Cruelty to Children Act, 1904, 558
Cyst, congenital, of lung with dextrocardia (George Carpenter), 160
— — of neck, 69
— dermoid, see *Dermoid cysts*
Cystitis, infantile, due to *B. Coli*, 331
Cystotomy, supra-pubic, for a foreign body, 432
Dactylitis, case of, with subcutaneous nodules, 261
Dairies, hygiene of, 76, 123
— insanitary, 450, 454
Death, sudden, after an operation for empyema, 478
— — and the thymus, 228
— — relation of status lymphaticus to, 189
Defective children in schools, 135
Deformities, congenital, see under *Congenital*
Degeneration, see *Physical degeneration*
Dent (C. T.), congenital hypertrophic stenosis of pylorus, 16, 38
Dermoid cyst of sternum, 75
Dextrocardia with congenital cysts of lung (George Carpenter), 160
Diagnosis, abdominal case for, 72
Diastasis of recti muscles in rickets, 240
Diet, evil effects of too soft (H. Campbell), 373
Diphtheria, 463
— bacilli in impetigo, 465
— embolism in, 466
— intubation in, 226
— primary tracheo-bronchial, 562
— scarlatiniform eruptions during, 463
— treatment of tracheotomy wounds in (A. E. Jones), 153
Diphtheritic paralysis and ascending paralysis, 465
— stenosis of larynx in children under 2 years; treatment, 522
Diplegia, anomalous case of, 34
— cerebral, with changes in the fundus oculi, 163
Diplococcus, Weichselbaum's lesions due to, 234
Diseases, infectious, and school life, 280
"Doctor and Schoolmaster" (E. Hobhouse), 417
Domestic economy, 84
— service, influence of, 87
Drew (D.), treatment of vesical calculus in children, 305
— see also *Parkinson (J. P.)*
Dropsy, essential in infancy, 467
Duodenum, ulcer of, in a child aged 44 hours (H. W. Kendall), 501
Dura mater, wound of, loss of cerebro-spinal fluid from, 432
Dysentery, epidemic, in children, bacteriology of, 469
Dyspepsia, infantile, and ferments in the mother's milk, 236
Dysphagia and congenital heart disease, 37
Dyspnœa from laryngeal obstruction, 331

Ear, actinomycosis of, 469
— deformity of, 164
— disease, cerebral abscess due to, 525
— middle and accessory cavities, tuberculosis of, 469

Ear, septic infection of, in nurslings, 333
Eczema, naso-labial, 525
Education of children from a practical standpoint, 323
— influence of, in certain forms of defective sight (J. A. Menzier), 422
— see also *Physical education.*
Effusion, hæmorrhagic, in acute tuberculous pericarditis, 565
Elbow-joint, tuberculous disease of, 311
Embolism in diphtheria, 466
Employment of children, 43, 224
Empyema, sudden death after an operation for, 478
Encephalitis associated with measles, 507
— case of, 260
Enteric fever in children, 229
— — optic papillitis in, 229
Enuresis in children (P. Lewis), 67, 146
— and frequent micturition in children, 428
Environment, effects of, 339
Eosinophilia in a breast-fed infant, 230
Epidermolysis bullosa, involvement of the eyes in, 562
Epidural injections in diseases of the urinary tract, 470
— — in treatment of incontinence of urine, 551
Epilepsy, relation of, to amentia (A. F. Tredgold), 291
— see also *Jacksonian epilepsy*
Epiphysis, ossification of, as a result of castration, 383
— bilateral separation of, of radius (J. W. T. Walker), 344
— separation of, 567
Epithelioma of the parotid gland in a child aged 6 years, 433
Eruption, facial, 210
Erythema, visceral manifestations of, 233
Ethmoid, resection of, for foreign bodies, 474
"Ethyl chloride" as a general anæsthetic (J. H. Chaldecott), 63
Eugenics, 271
Evans (J. H.), relation of certain extra- and intra-cranial hæmorrhages in the new-born, 207
Examination, see *Rectal examination*
Exanthemata, gonorrhœal, in new-born infants, 459
Exercise, see *Physical training*
Exophthalmic goitre, see *Goitre*
Experiments, 85
Extremities, hypertrophy of, 258
Eyes, foreign bodies in, in children (S. Stephenson), 489
— involvement of, in epidermolysis bullosa, 562
— see also *Microphthalmos*

Facial lesions and injection (F. H. Barendt), 210
Fallopian tubes, see *Salpingitis*
Family type of progessive cerebral degeneration, 163
— — — muscular atrophy, 362
Favus in the new-born, 238
Fede's disease, 281
Feeble-minded, care of, 222
— see also *Mental deficiency*
Feeding, artificial, choice of milk for, 471
— — comparative mortality and (H. Armstrong), 115
— — — during the first two years of life, 471
— of infants, biological consideration on, 431
— see also *Buttermilk* and *Milk*
Femur, fracture of in a hæmophilic (K. Monsarrat), 494
Ferments in mother's milk and infantile dyspepsia, 236
Ferroleum, 98
Fersan, therapeutics of, 384, 473
Fever, continued in infants, forms of, 279
Fingers, deformity of, 523
— see also *Dactylitis*
Fisher (T.), visceral crises in Henoch's purpura, 96
Fœtus, achondroplasia in, 324
— heart-murmurs in, 326
Folkestone, child study at, 45
— Congress at, 370, 411
— schools at (Sir C. Cameron), 374
Food, see *Diet, Feeding*, and *Meals*
Foot, abductor reflex of, 329
— deformity of, 74, 214
Foreign bodies in bronchi, extraction of, 476
— — in the eyes of children (S. Stephenson), 489
— — in larynx and the bronchi, 231
— — — of an idiot, 334
— — resection of the ethmoid for, 474
— — in the right bronchus, 570
— — suprapubic cystotomy for, 432
— — in trachea, recovery, 144
France, care of poor children in, 134
— Gouttes de lait in, 167
Freidreich's disease, early case of, 164
Fundus oculi, changes in, with cerebral diplegia, 163

Gall-Bladder and bile-ducts, congenital dilatation of, 478
Ganglia, see *Nerve ganglia*
Gastro-enteritis, action of saccharomyces on the *B. coli*, 473
Gastro-intestinal disorder after weaning, abuse of milk in, 521
Giese's syndrome, case showing, 350
Gilford (S.), two cases of diaphragmatic hernia, 536
Glas-Sedlbauer portable lamp for light cure of lupus, 529

Glenton-Kerr (T.), administrative notes on Children's Hospitals, 32, 69
Glioma of the pons (G. A. Sutherland and E. Holland), 203
— and pseudo-glioma, 228
Glottis, infectious œdema of, 231
Goitre, congenital, 476
— exophthalmic, case of, 73
— — case of chronic (E. C. Williams), 501
Gonococcal infections in childhood, 447
— peritonitis in children, 458
Gonorrhœa in children, 459
— in infants, with a report of eight cases of pyæmia, 459
Gonorrhœal arthritis, secondary to conjunctivitis, in a new-born child, 522
— exanthemata in new-born infants, 459
— inflammation of the uterine appendages detected by bimanual examination (George Carpenter), 437
— peritonitis, secondary to vulvo-vaginitis, 458, 459, 460
— salpingitis in a child aged six (L. A. Bidwell), 435
— urethritis in young boys, 457, 460
Gouttes de Lait, 167
Grancher's disease in a child of three years, 279
Graves' disease, see *Goitre exophthalmic*
Groats, Robinson's patent, 98
Grünbaum (O.), congenital trophic œdema, 531

Habit-spasm, case of, 504
Hæmatoma of parietal bone, 164, 214
Hæmaturia, scurvy as a cause of, 181
Hæmophilic, fracture of the femur in a (K. Monsarrat), 494
Hæmorrhage, adrenal, 239
— extra and intra-cranial in the new-born (J. H. Evans), 121, 207
Hair, premature greyness of, 36
Hands, use of both, 223
Hare-lip, ill-developed lateral incisor tooth as a forerunner of (R. C. Lucas), 483
Harris (H. E.), cases of congenital deformities, 502
Heart, cardiac area in children, 560
— dilatation of, with mitral disease, 214
— disease of, congenital, 509
— — with dysphagia, 37
— — — in a girl, 75
— displacement of, with congenital cysts of the lung (George Carpenter), 160
— murmurs, fœtal, 326
Hemicrania, with third nerve paralysis (J. Taylor), 4
Hemihypertrophy, organs from a case of, 166
Henoch's purpura, etiology of visceral crises in, 38
— — in which laparotomy was performed (H. Burrows), 28
Henoch's purpura and intussusception (G. A. Sutherland), 23
— — visceral crises in (T. Fisher), 96
Hereditary bias, etc. (Wightman Lecture), 339
— trophic œdema, 505
— syphilis, transmission of, to second generation, 562
Heredity, a factor in the ætiology of rickets, 466
— and mental deficiency, 101
Hernia, congenital diaphragmatic, two cases of (S. Gilford), 479, 536
— infantile, literature upon, 245
— strangulated, four cases of operation for, 333
— — inguinal, in infant aged 28 days, operation, recovery (R. C. Lucas), 243
— treatment of, in young children (P. L. Mummery), 253
— umbilical cord, 480
— in young children, treatment of, 166, 523
— — — operative treatment of, 524
Herpes zoster, extending to the finger-tips (George Carpenter), 510, 545
— — from administration of arsenic (J. H. Sequeira), 158
— — infantile, 378
— — paralysis of the left trapezius muscle after, 313
Hip disease, treatment of, old dislocation of, congenital, 95, 475
— — Lorenz method in two cases of, 363, 524
— — spontaneous, 434
— — see also *Coxa vara*
Hobhouse (E.), "Schoolmaster and Doctor," 417
Holland (E.), see *Sutherland (G. A), and Holland, Glioma of pons*, 203
Horlick's malted milk, 50
Hospital, Liverpool County, 128
Hospitals, children's, administrative notes on (T. Glenton-Kerr), 69, 32
— — milk dispensaries for, 123, 194
Housekeeping by schoolgirls, 84
Hussey (A. L.), night terrors and sleep-walking, 396
Hutchison (R.), case of hemihypertrophy in which the internal organs were affected, 258
Hydatid cyst of, brain (H. Ashby), 51
Hydrocephalus, case of, cured (J. M. Clarke), 503
— cases of, 362
— chronic, with endothelioma of brain (W. C. Chaffey), 195
— drainage of ventricles into subdural space established in (C. A. Morton), 387
Hydrogen peroxide solution in thrush, 236
Hygiene, compulsory teaching of, 88

Hygiene, teaching of elementary, in London, 312, 377
Hypertrophy, hemi-, organs from a case of, 166
— in which the internal organs were affected (R. Hutchison), 258
Hypnotic suggestion in a case of abasia, 383
Hypnotism, see also *Suggestion*
Hypogastric reflex, 286
Hysteria in childhood, 143, 324

Idiocy, 103, 291
— profound, with infantilism, 140
— see also *Amaurotic idiocy, Mongolian idiocy*
Idioglossa in twin sisters, 35
Imbecility, 291
— with irregular movements, etc., 509
Impetigo contagiosa bullosa, 37
— diphtheria bacilli in, 465
Incisor, see *Tooth*
Infant murderers, 510
— feeding, see *Feeding of infants*
— — in France, 167
Infantilism, pancreatic case of, 283
— in Pott's disease, 324
— with profound idiocy, 140
Infants, premature care of, 431
— in workhouses, care of, 267
— new-born, see *New-born*
Infarct, hæmorrhagic, of testicle, 275
Infection, common facial lesions and (F. H. Barendt), 210
Infections of the new-born, 138
Influenzal meningitis, 430
Insane, general paralysis of, 36
Insanity, infantile, in its relation to crime, 138
Intestines, diseases of, tannin preparations in, 327
— tuberculosis of, 91
Intubation in croup and diphtheria, 226
— tube in the right bronchus, extraction, 570
Intussusception, case of, with cure by sloughing, 477
— caused by sloughing, 569
— and Henoch's purpura (G. A. Sutherland), 23
— infantile, 335
Iritis, fibrinoplastic in a newly-born baby, 237
Iron-vitellin treatment in anæmia in children (George Carpenter), 349

Jackson (J.), ambidexterity: its advantages, 418
Jacksonian epilepsy in a child aged 2 years relieved by operation, 276
Jacob (F. H.), see *Marshall (L.), pseudo-bulbar paralysis*, 199
Jaw, mercurial necrosis of, 567
Jews and amaurotic idiocy, 142
Joint, diseases of, and reflex atrophy, 325
Jones (A. E.), treatment of tracheotomy wounds in diphtheria, 153

Kekewich (Sir G.), physical education, 353
Kendall (H. W.), duodenal ulcer in a child aged 44 hours, 501
Kernig's sign, 378
Kerr (T. G.), see *Glenton-Kerr (T.)*
Kidney, atrophy of one, 328
— disease and retinitis, 182
— inflammation of, see *Nephritis*
— microscopic section of, from case of general œdema, 165
— multiple lipoma of, 479
— stone in, see *Calculus, renal*
Kingsford (W. B.), the inclusion of physiology in the curriculum of elementary schools, 415

Lachrymal sac, tuberculosis of, 165
Lactation, return of mother's milk to colostral state in, 330
Lamp, Glas-Sedlbauer portable, for light cure of lupus, 529
Laparotomy in Henoch's purpura (H. Burrows), 28
Laryngeal stridor, congenital, 379
Larynx, diphtheritic stenosis of, in children under 2 years, treatment, 522
— foreign body in, 231
— — — in an idiot, 334
— spasm of, 316
Lead-poisoning, unique case of, in an infant, 236
Leg, hypertrophy of, 503
Leprosy, heredity in, 340
Leucocytes, enumeration of, 380
Lewis (P.), enuresis, 67
Light treatment of lupus, portable lamp for, 529
Lip-tie, 278, 434
Literature, abstracts from current:
Laryngology, 525
Medicine, 45, 89, 136, 181, 228, 279, 324, 378, 426, 457, 517, 559
Otology, 525
Pathology, 89, 136, 382, 429, 465, 568
Rhinology, 525
Surgery, 89, 190, 227, 275, 331, 384, 432, 473, 532, 567
Therapeutics, 89, 383, 431, 470
— pernicious, 178
Lithiasis, renal, in children, 477
Liver, function of, in children, 238
— and spleen, enlarged, 214
Liverpool Corporation, distribution of sterilised humanised milk by, 176
— County Hospital for Children, 128, 176, 242
London, infant mortality in, 134
Londoners, difference in vision between country children and (William Freeman), 424

Lorenz, method, 363, 524
Lucas (R. C.), on an ill-developed upper lateral incisor tooth as a forerunner of harelip or cleft palate, 483
— strangulated inguinal hernia in infant 28 days old, operation, recovery, 243
— Wightman Lecture on hereditary bias, etc., 339
Lumbar puncture in chorea, curative value of, 563
— — diagnosis of tuberculous meningitis and, 565
— — indications for, 326
— — a year's experience of, 429
Lung, angiosarcoma of, secondary, 164
— cirrhosis of, 74
— congenital cysts of, with dextrocardia (George Carpenter), 162
— cystic disease of, 75
Lupus, Glas-Sedlbauer portable lamp for treatment of, 529
Lymphangioma, some cases of (A. Carless), 56
Lymphatic cyst, congenital, of the axilla, 276
Lymphatism, 186
— see also *Status lymphaticus*

McKenzie (D.), appendicitis discovered by rectal examination, 542
— fatal staphylococcus mouth infection following measles, 117
Mackey (C.), two cases of ptomaine poisoning, 496
Macrodactyly, cases of, 523
Magnesia, Phillips' milk of, 578
Maltica, 98
Marasmus, case of extreme, 122
Marshall (L.), congenital cyst of neck of infant, 69
— and F. H. Jacob, pseudobulbar paralysis due to bilateral tuberculous tumour, 199
Mastoid cicatrix over, softening of, in course of scarlet fever, 526
Meals before lessons, 271, 323
Measles, associated with encephalitis, 507
— croup complicating, 241
— fatal staphylococcus mouth infection following (D. McKenzie), 117
— mortality of, 235
— polioencephalitis occurring during, 508
Mediastinitis, case of, 73
Megacolon, congenital, 287
Mellin's food, 50
Meningitis complicating mumps, 288
— as a complication of pneumonia, 563
— influenzal, 430
— latent, in pneumonia, 287
— pneumococcic cerebro-spinal, benign course of, 427
— post-basal, due to *Pneumococcus lanceolatus* (J. P. Parkinson), 112
Meningitis, pseudo-, in the course of chorea, 461
— tuberculous, diagnosis of, by lumbar puncture, 565
Meningocele and congenital proptosis, 260
Menstruation and the temperature of breast-fed infants, 462
Mental deficiency, 291
— — cerebral surgery in, 384
— — in children (G. E. Shuttleworth), 99
— — pathology of, 139
— — rickets and, 140
— training of children, 83
Menzies (J. A.), influence of certain forms of defective sight on education, etc., 422
Mercurial necrosis of the jaw, 567
Mesentery, embryonic cyst of, 216
Metatarsalgia, symptomatic, in paralytic talipes, 569
Microphthalmos, two cases, one slight, the other extreme (S. Stephenson), 251, 261
Micturition, frequent, and enuresis in children, 428
Milch cows, care of, 454
— — in Great Britain, 132
Milk, abuse of, in chronic gastro-intestinal disorders after weaning, 521
— action of rennet upon the digestion of, 327
— choice of, for artificial feeding, 471
— dispensaries for children's hospitals, 123, 194
— feeding in infants, abuse of, 288
— ferments in, and infantile dyspepsia, 236
— human, estimation of proteid in, 520
— return of, to colostral state, during lactation, 330
— shops, municipal, 450
— sterilised humanised, distribution of, 176
— supplied to infants, 76
— supply of, in France, 167
— — municipal, 216
— tuberculosis and, 90
— see also *Tuberculosis*
Mitral disease with attacks of dilatation of the heart, 214
Mongolian idiocy, 142
— — treatment of, 142
Monsarrat (K.), fracture of femur in a hæmophilic, 494
Monstrosity, rare, of face and brain, 286
Mortality, infantile, and feeding, 115
— — in London, 134
— — public health authorities, 453
Morton (C. A.), case of hydrocephalus, drainage of ventricles into subdural space established, 387
— case of valvular urethral obstruction, etc., 348

Morton (C. A.), valvular obstruction of urethra of infant, secondary changes in urinary organs, 500
Mouth, staphylococcus infection of, following measles (D. McKenzie), 117
Mummery (P. L.), diagnostic value of a rectal examination in children, 443
— the treatment of hernia in young children, 253
Mumps, meningitis complicating, 288
Murder by infants, 510
Muscles, clonic contraction of, 262
Myelitis, urinary incontinence in, 461
Myocardial insufficiency, acute, 563
Myocarditis, uncomplicated, in a girl aged eight (George Carpenter), 518
Myokynia in acute polioencephalo myelitis, 517
Myopathy, progressive, with sensory changes, 518
Myositis ossificans, 235, 326

Nævi, treatment of, by radium, 324
Naso-labial eczema, 525
Neave's food, 386
Neck, congenital cyst of (L. Marshall), 69
Necrosis, see *Jaw*
Nephrectomy for tuberculous pyelonephritis, 475
Nephritis, chronic interstitial, 136, 185, 215
— — in the young, 428
— infantile, 240
— — scurvy and, 464
— — in new-born and young infants, 184
— peri-, in children, 479
— surgical treatment of acute and chronic, 385
— toxic, suppression of urine for seven days from, 427
Nephro-lithotomy in a case of renal calculus (J. P. Parkinson and D. Drew), 441
Nerve ganglia of heart, stomach, and intestines, influence on, of intoxication by the Bacillus coli, 467
— third, paralysis of, with hemicrania (J. Taylor), 4
Nervous system, diseases of, heredity in, 342
Neurasthenia, infantile, 142
Neuritis, ascending and diphtheritic paralysis, 465
— double optic, as complication in whooping cough, 229
New-born, acute fibrino-plastic iritis in, 237
— children of syphilitics, 281, 559
— disturbance of suction in, 288
— extra-, and intra-cranial hæmorrhages in (J. H. Evans), 121, 207
— favus in, 238
— gonorrhœal arthritis, secondary to conjunctivitis in, 522
New-born, exanthemata in, 459
— infections of, 138
— nephritis in, 184
— pemphigus of, 95
— sclerema and scleroderma in, 284
New Zealand State socialism in regard to infant lives, 322
Night-terrors and sleep-walking (A. L. Hussey), 396
Nodules, tuberculous multiple subcutaneous, 35
Nursing schools for girls, 44
Nystagmus, vertical monocular, 164

Œdema, congenital trophic (O. Grünbaum), 531
— general, in an infant, 165
— hereditary trophic, 505
— infectious, of glottis, 231
Œsophagus, congenital occlusion of, 333
— — stricture of, 362, 364
— — — (B. M. H. Rogers), 390
— tubercle of, 568
Ophthalmoplegia, bilateral, internal, and hereditary syphilis, 238
— case of, with cerebral degeneration, 506
Osteo-arthropathy, pulmonary, 93
Osteomyelitis, infective, its pathology and treatment, 277
Otitis, cerebral abscess from, 474

Pain, asymmetry in sensation of, 284
Pancreatic extract in infantilism, 283
Papillitis, optic, in enteric fever in children, 229
Paraglandin, therapeutic indications of, 330
Paragangline in the treatment of chronic prolapse of the rectum, 567
Paralysis, amentia, and epilepsy, 300
— diphtheritic and ascending neuritis, 465
— emission of N rays in, 325
— general, of insane, 36
— infantile, epidemic of, 517
— pseudo-bulbar, due to bilateral tuberculous tumours (L. Marshall and F. H. Jacob), 99
— of third nerve with hemicrania (J. Taylor), 4
Paramyoclonus multiplex, 262
Paraplegia, spastic, in a child, 378
Parietal bone, hæmatoma of, 164, 214
Parkinson (J. P.), post-basal meningitis due to the Pneumococcus lanceolatus, 112
— and D. Drew, case of renal calculus, nephrolithotomy, 441
Parotid gland, epithelioma of the, in a child aged 6 years, 433
Parrot's nodes, specimen of early, 216
Pauper children, boarding out of, 515
— — care of, 321
Peacocke, (G.), constitutio lymphatica, 186
Pediatrics, promotion of study of, 554

Pemphigus of the conjunctiva, 228
— neonatorum, 95
"Penny dreadfuls," 178
Percussion of cardiac area in childhood, 560
Pericarditis hæmorrhagic in acute fatal chorea, 287
— tuberculous, acute, with large hæmorrhagic effusion, 565
Perinephritis in children, 479
Peritoneum, tuberculosis of, operative treatment of, 475
Peritonitis, gonococcal, in children, 458
— gonorrhœal, secondary to vulvo-vaginitis, 458, 459, 460
— pneumococcic, in children, 523
— tuberculous, 429
— — ascites in, effect of diet, 381
Pernet (G.), antiquity of achondroplasia, 7
Peroxide, see *Hydrogen*
Perversion, moral, relation of infantile insanity to, 138
Pes cavus, double, 74, 214
Philadelphia Pediatric Society, 131
Phosphorus in the treatment of rickets, 285
Physical degeneracy, 86, 133
— education (Sir G. Kekewich), 353
— training in the primary schools, 273
Physiology, inclusion of, in the curriculum of elementary schools (W. B. Kingsford), 415
Pleurisy, acute serous, at three months old, 327
Pneumococcic cerebro-spinal meningitis, benign course of, 427
— peritonitis in children, 523
— pyæmia, 568
Pneumococcus lanceolatus, meningitis due to (J. P. Parkinson), 112
Pneumonia, latent meningitis in, 287
— lobar, in children, 561
— — — (B. Abrahams), 150
— meningitis as a complication of, 563
— modifications of arterial tension in, 237
— recurrent, 465
— spleno-, in a child aged 3 years, 279
Pneumothorax, 93
Polioencephalitis occurring during measles, 508
Polioencephalomyelitis, acute, myokynia in, 517
Poliomesencephalitis of Wernicke, hæmorrhagic, showing Benedict's inferior syndrome, 426
Poliomyelitis, acute anterior, 382
Polyuria in a child aged 3 years, 184
Pons, glioma of (G. A. Sutherland and E. Holland), 203
Ponto-medullary tract, tuberculous nodule in, 261
Poor-law children's teeth, 513
Pott's disease, infantilism in, 324
Pott's disease, ultimate fate of sufferers from, 473
Poynton (F. J.), influence of school life upon rheumatic children, 413
Prevention of Cruelty to Children Act, 1904, 558
Proptosis, congenital and meningocele, 260
Proteid, estimation of, in human milk, 520
Protylin, therapeutics of, 241, 384
Psoriasis infantilism, 45
Psychoses, juvenile, originating in whooping cough, 143
Ptomaine poisoning, two cases of (C. Mackey), 496
Public health authorities and infantile mortality, 453
Pulsation, capillary, in urticarial wheals, 309
Punishment of children, 226
Purpura myeloid, analogy with, in Barlow's disease, 382
— see also *Henoch's purpura*
Pyæmia, pneumococcic, 568
— report of eight cases of infantile gonorrhœa, 459
Pyelitis, acute primary, 93
Pyelonephritis, tuberculous, nephrectomy, 475
Pyloroplasty, 384
Pylorus, congenital hypertrophic stenosis of, 95, 331, 384
— — — (E. Cautley), 10, 37
— — — (C. T. Dent), 16, 38
— spasm of, 281

Rachiodocentesis, see *Lumbar puncture*
Radium in the treatment of nævi, 334
Rays, see *N rays*
Rectal examination, appendicitis in a child discovered by (D. McKenzie), 545
— — diagnostic value of (P. L. Mummery), 443
Recti muscles in rickets diastasis, 240
Rectum, prolapse of, chronic, treatment by paragangline, 567
— — — operative treatment of, 226
Reflexes, acromial, 285
— hypogastric, 286
— tendon, loss of, in cerebral tumour, 285
Rennet, action of, upon the digestion of milk, 327
Respiration, normal, importance of, as a factor in physical and mental development (P. W. Williams), 211
Respiratory spasm, 282
Retina, glioma of, 228
Retinitis, renal observation on, 182
Reviews of books—
Bourneville.—Recherches sur l'Epilepsie, l'Hysterie, et l'Idiotie; Compt.-Rendu du Service des Enfants Idiotes, Épileptiques et Arrières de Bicêtre Pendant l'Année, 1902, 570

Reviews of books—*continued*
Carpenter (George).—Reports of the Society for the Study of Disease in Children, vol. iii, 48
Cumming (J.).—Aids to Surgery, 337
David (E.).—Les Lésions Experimentales du Système Nerveux Sympathique Influent-elles sur la Pénétration de la Toxine Diphterique et sur la Resistance Organique ?, 336
Holt (L. E.).—The Care and Feeding of Children, 5th edit., 242
Lake (R.).—Handbook of Diseases of the Ear, 338
Leedham-Green (C.).—The Sterilisation of the Hands, 576
McCaw (J.).—Aids to the Treatment of Disease of Children, 2nd edit., 48
Mummery (P. L.).—The After-treatment of Operations, 289
Pharmacopœia (The) of the North-Eastern Hospital for Children, 290
Prichard (E.).—The physiologial feeding of infants, 191
— — — nursery chart, 192
Report of the Medical Officer of the late London School Board for year ending March, 1904, 480, 527
Senator (H.) and S. M. Kamaier.—Health and Disease in Relation to Marriage, translated by J. Dulbery, 528
Smith (N.).—Lateral Curvature of the Spine, 193
Taylor (F.).—Some Disorders of the Spleen, 577
Tubby (A. H.) and R. Jones.—Modern Methods in the Surgery of Paralysis, 145
Vincent (R.).—The Nutrition of the Infant, 144
Williams (W. R.).—Vaginal Tumours, with special reference to cancer and sarcoma, 289
Wingrave, (W.).—Adenoids. Medical monograph series IX, 482
Rheumatism in children, effect of school life upon (F. J. Poynton), 413
— polyarthritis tuberculous, etc., in a girl aged 10 years, 462
— some of the less commonly recognised manifestations of (J. Burnett), 392
Rickets, ætiology of, 466
— diastasis of the recti muscles in, 240
— feeble-mindedness and, 140
— heredity in, 341
— phosphorus in the cure of, 285
— physical sign of, 518
Riga's disease, 281
Robinson's Patent Barley, 98
— — Groats, 98
"Roche," see *Thigenol roche*
Rogers (B. M. H.), case of congenita stricture of the œsophagus, 390
Royal Institute of Public Health Congress at Folkestone, 370, 411

Saccharomyces cerevisia, action of, on the B. coli in infantile gastro-enteritis, 473
Salpingitis, gonorrhœal, in a child aged 6 years (L. A. Bidwell) 435
Sarcoma, 37
— angio- of lung, 164
— with secondary deposits, 120
Sarcomata, multiple, of the scalp, 310
Scalp, multiple sarcomata of, 310
Scapula, congenital elevation of, 278
Scarlatiniform eruptions during diphtheria, 463
Scarlet fever, serum therapy of, 91
— softening of a cicatrix over mastoid in, 526
—weight variations in, 329
School children at Clitheroe to be medically examined, 272
— — hungry, 44
— -girl housekeepers, 84
— life and infectious diseases, 280
— — influence of, upon rheumatic children (F. J. Poynton), 413
— -master and doctor (E. Hobhouse), 417
Schools, defective children in, 135
— food in, 374
— hygiene of, 417
— — Congress at Folkestone, 370, 374, 411
— physical training in, 273
— teaching of hygiene in, 88, 377
— — — physiology in, 415
Scleremа, 239
— in new-born infants, 284
Sclerodermа in new-born infants, 284
Scottish therapeutics, 232
Scurvy, cases of infantile, 181
— as a cause of hæmaturia, 181
— infantile, discussion of its causes, 329
— — nephritis and, 464
Sequeira (J. H.), Herpes zoster and bullous eruption from administration of arsenic, 158
Serum therapy, 91
Sex, errors of, revealed by surgical operation, 190
Shuttleworth (G. E.), mental deficiency in children, 99
Sight, see *Vision*
Skull, steeple-shaped, 46
— tuberculosis of, craniectomy, 474
Sleep-walking and night-terrors (A. L. Hussey), 396
"Smacking," art of, 226
Smoking, juvenile, 452
— see also *Tobacco*
"Snuffles," 559

Society for the Study of Disease in Children meetings, papers, reports, etc., 34, 72, 119, 163, 214, 260, 310, 361, 366, 503, 546
Sociological Society of London, 219
Sodium, chloride of, in cerebro-spinal fluid of sick children, 430
Somnambulism, 396
Somnoform, hystero-epilepsy reproduced by, 461
Speech, defects of, in twin sisters, 35
Spencer (H.), and vaccination, 179
Spermatic cord, torsion of, and hæmorrhagic infarct of the testicle, 275
Spinal cord, tuberculous tumours of, pseudo-bulbar paralysis due to (L. Marshall and F. H. Jacob), 199
Spine, lateral curvature of, functional, 235
— tuberculous caries of upper dorsal, 75
Spleen and liver, enlargements of, 214
Staphyloma, congenital, of the cornea, 238
Staphylococcus mouth infection following measles (D. McKenzie), 117
"State children," 220
Status lymphaticus, 310, 316, 566
— — relation of, to sudden death, 189
Stenosis, see *Pylorus, stenosis*
Stephenson (S.), foreign bodies in the eyes of children, 489
— two cases of microphthalmos, one slight, the other extreme, 251, 261
Sternum, dermoid cyst of, 75
Stiles (H. J.), and S. McDonald, delayed chloroform poisoning, 262, 401
Stomach, hypertrophic stenosis of, 38
— ulcer of, perforated, 312
— — — perforating in a young child, 280
Stomatitis, ulcerative, fatal, following measles (D. McKenzie), 117
Streptococci, scarlatinal and serum therapy, 279
Stridor, congenital laryngeal, 379
"Sublingual production," 281
Suction in newly-born, disturbance of, 288
Sugar-plums, baptismal, 88
Suggestion during sleep, 282
Suicide in childhood, 560
Sutherland, (G. A.), intussusception and Henoch's purpura, 23
— and E. Holland, case of glioma of the pons, 203
Swallowing, see *Dysphagia*
Swedish exercises, 273
Syphilis, congenital, cerebro-spinal form of, 461
— hereditary and bilateral internal ophthalmoplegia, 238
— heredity in, 341
— — transmission of, to the second generation, 562
— see also *Parrot's nodes*
Syphilitic coryza of the new-born, 559
Syphilitics, treatment of new-born infants of, 281

Tabes, juvenile, case of, 283
Tabetics, vitality of children of, 46
Tænia mediocanellata and mother, and eosinophilia in breast-fed infant, 230
— solium, association of chorea with (J. Burnet), 147
Talipes, paralytic, symptomatic metatarsalgia, 569
Tannin preparations, value of, in infantile intestinal lesions, 327
Tapeworms, treatment of, 230
Taylor (J.), case of hemicrania with third nerve paralysis, 4
Teat comforters, danger of, 88
Teeth of children, case of Poor-law, 513
— — in relation to public health, 372
Temperature of breast-fed infants during maternal menstruation, 462
Temporo-sphenoidal abscess, operated upon seventeen years ago, 525
Teno-synovitis, chronic polyarthritis, rheumatism, etc., in a girl aged 10 years, 462
Testicle, hæmorrhagic infarct of, and torsion of the spermatic cord, 275
Tetanus, recovery from, cases of, 379
Thigenol "roche," therapeutics of, 470
Thrush, treatment of, by peroxide of hydrogen solution, 236
Thymus and status lymphaticus, 318
— — sudden death, 228
Thyroid treatment of cretinism, 380
— — of Mongolian idiocy, 142
Tobacco-smoking by boys, 79, 133, 225, 452
Toes, abduction of, 284
Tongue, tumour at root of, 73
Tonsils, actinomycosis of, 384
— cartilaginous and bony nodules in the, 433
— hypertrophied, topographical anatomy of crypts of, 277
— rash following removal of, 227
— tuberculosis of, 91
Tooth, incisor, ill-developed upper lateral, as forerunner of hare-lip or cleft palate (R. C. Lucas), 483
Trachea, piece of coal in, recovery, 144
Tracheo-bronchial diphtheria, primary, 562
Tracheotomy wounds in diphtheria, treatment of (A. E. Jones), 153
Tramp children, 44
Tredgold (A. F.), on the relation of epilepsy to amentia, 291
Trichotillomania, a case of, 509
Tubercle, nomenclature of, 269
— bacilli in the cerebro-spinal fluid, means of discovering, 234
— — in the meninges, action of, 382

Tuberculosis, infantile, 340
— of œsophagus, 568
— peritoneal, operative treatment of, 475
— rheumatism, polyarthritis, etc., in a girl aged 10 years, 462
— transmission of, by milk, 90
— — — (A. P. Allan), 146
Tuberculous nodules, multiple subcutaneous, 35
Turner (J. G.), teeth of children in relation to public health, 372
Twin sisters with idioglossia, 35

Umbilical cord, hernia of, 480
Urethra, obstruction of, etc. (C. A. Morton), 348
— valvular obstruction in, with secondary changes in urinary organs in an infant, 500
Urethritis, gonorrheal, in young boys, 457, 459
Urinary diseases, epidural injections in, 470
— organs, secondary changes in, in valvular obstruction of urethra (C. A. Morton), 348, 500
Urine, incontinence of (P. Lewis), 67
— — — epidural injections in treatment of, 551
— — — in myelitis, 461
— suppression of, for seven days from toxic nephritis, 427
— see also *Polyuria*
Urticaria in infancy, ætiology of 234
Urticarial wheals, capillary pulsation in (George Carpenter), 309
Uterine appendages, gonorrhœal inflammation of, in child aged 3½ years detected by bimanual examination (George Carpenter), 437

Vaccination and H. Spencer, 179
Veronal, new hypnotic, 473
Vertebra, 5th cervical, congenital dislocation of, 120
Vertebra, tuberculosis of, operative treatment of, 191
Virol, 578
Viscera, transposition of, 119
Visceral crises in Henoch's purpura, 38
— — — — — (T. Fisher), 96
— manifestations of erythema, 233
Vision, defective, influence of certain forms of, on education (J. A. Menzies), 422
— differences in, between country children and Londoners (Williams-Freeman), 424
Vitellin, see *Iron-vitellin*
Vulvo-vaginitis, peritonitis as a complication in, 458, 459, 460

Wales, H.R.H. Princess of, and the British Journal of Children's Diseases, 122
Walker (J. W. T.), case of bilateral separation of lower epiphysis of radius, 344
Warts, flat, 239
Wasting, see *Marasmus*
Water as a drink, 86
Weaning, chronic gastro-intestinal disorders after, 521
Weichselbaum's diplococcus lesions due to, 234
Weight, variations in scarlet fever, 328
Wernicke's hæmorrhagic poliomesencephalitis, 426
Whooping-cough, double optic neuritis as complication in, 229
— — juvenile psychoses originating in, 143
— — treatment of, 45
Wightman lecture (R. C. Lucas), 339
Williams (E.C.), case of chronic Graves' disease, 501
Williams (P. W.), importance of normal respiration as a factor in physical and mental development, 411
Williams-Freeman, differences in vision between country children and Londoners, 424
Word-blindness, congenital, 521
Workhouses, care of infants in, 267
Worms, intestinal, toxicity of, 229

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